International Conference

Preventing violence, Caring for survivors

Role of health profession and services in violence

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CONFERENCE PAPERS

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(1) Papers are organised in alphabetic order by the first author name, separately for papers and abstracts

(2) All Presentations in Group Discussion Sessions are for only TEN minutes

(A) ABSTRACTS

(B) PAPERS

In addition, three published papers are provided separately:
(1) By Amar Jesani, in *Radical Journal of Health,* **(2) By Lalitha D'Souza, in** *Issues in Medical Ethics,* **(3) By Kannama Raman,** *Mumbai University Publication.*

ABSTRACTS

(Total: 38)

CEHAT, Mumbai, India

Abstract: 1

Response of doctors to communal conflict

Ali Asghar
Confederation of Voluntary Agencies
Hyderabad, India

It deals with the reactions of doctors working in casualty section to communal conflict situations both as persons and as professionals.

* The pressures and constraints under which the doctors work during such situations.
* The contingency plans that become operational during conflict situations.

The paper also takes a look at the hospital conditions and doctors' response from the point of view of the victims.

* The attention the victims received.
* The perceived bias of the doctors.
* The lack of medicines at the hospitals and difficulty faced in procuring medicine during the riot period.

Abstract: 2

The violence of medical knowledge

Anand Zachariah
Christian Medical College and Hospital
Vellore, India

The presentation examines the philosophical framework of medical knowledge, which separates disease from the experience of the sufferer. This framework eliminates the subjective elements of illness in favour of a disease description in terms of anatomy, physiology and pathology. It emphasises science based on empirical observation and underplays values such as patient experience. This examination, the arrangement of the hospital system, multi-speciality care, the exclusion of the family, the emphasis on drug treatments and the separation from other systems of medicine. The practicing physician has to negotiate this dichotomy every day in order to care for the individual patient.

The presentation will be based on a few case histories that are used to discuss the philosophical problem of medical knowledge.

Abstract: 3

Human rights in prisons: Role of medical professionals

Arvind Tiwari
Commonwealth Human Rights Initiative
N. Delhi, India

The role and functioning of prisons in India has been a matter of intense debate and scrutiny at various officials and non-official forms for several decades now. Through imprisonment has been the oldest and most universal mode of dealing with offenders who endanger peace and tranquillity in society, never before in its history, prison administration has been subjected to such as questioning and criticism as at present. The reasons of this scrutiny had been firstly, recognition of prisoners rights movement, secondly, the emergence of the notions of as reasonable and a fair state administration and thirdly, to through open all public institution to close scrutiny and public accountability.

There is no dearth of thinking on the problems in and perspective of prison reforms. As early as 1920, the Indian Jail Committee laid the base of the stream lining of prison system. In 1951, Dr. W. C Reckless from the United Nations prepared a blue print for prison development on contemporary lines. In 1959, the All India Jail Manual Committee formulated the Model Prison Manual as a concrete plan for prisons re-structuring. The All India Committee on Jail Reforms, 1980-83 popularly known as Mulla Committee had analysed in detailed the basic problems confronted the system and identified areas of concerted action. In recent years, the advocacy for the protection of human rights of persons in prison custody had found its expression in a number of judgements delivered by the Supreme Court of India. The National Human Rights Commission (NHRC) since its inception has intensified its efforts to improve prison conditions and prepared a draft bill to replace Indian Prison Act of 1894 with contemporary penological and criminological thinking.

The present paper highlights the role of Medical officials and para-medical staff to improve the conditions relating to the care and treatments of prisons undergoing incarceration for the viewpoint of their human rights.

Abstract: 4

Survival beyond violence

Devenprabhu Doss
CMCH
Vellore, India

This paper deals with the rehabilitation of survivors of violence. People who survive violence, experience long term physical and psychological suffering. This paper suggests different coping strategies to reduce the long-term impact of violence on the victim.

Abstract: 5

WHO initiatives to address violence against women

Iris Tetford
WHO
Geneva, Switzerland

Violence against women is a risk factor for many negative health outcomes, such as physical injury, depression, STDs and unwanted pregnancies. Violence therefore must be viewed in the broad context of women's health. A public health approach requiring action from many sectors is necessary and the relationships between these different outcomes needs to be understood when addressing the problem of violence. While recognising the need for a multi-sector approach, the focus of WHO's work is on identifying and supporting the role of the health sector in both the prevention of violence and the provision of care for those women who have been abused.

This presentation outlines WHO's activities

In early 1996, WHO held an Expert Consultation in Geneva on violence against women. It focused on violence against women in families, as this is one of the most prevalent forms of violence against women, together with rape and sexual assault. The recommendations made to WHO have provided the basis for the work of the Women's Health and Development.

In 1996 the World Health Assembly adopted Resolution WHA 49.25, which declares violence a public health priority and calls for a science-based plan of action for the prevention of violence.

- *Research and development of research methods*, including implementation of a multi-country study on the prevalence, risk and protective factors and health consequences of violence against women.
- *Data collection and dissemination*, including the development of a database on violence against women, to collect information on the prevalence of domestic violence in families, rape and sexual assault, and their consequences to the health of women and families.
- *Definitions and international reporting standards*, including developing a manual on research methodologies for the study of violence against women.
- *Advocacy and information*, including increasing sensitivity to violence among researchers, policy-makers and health providers and the production and dissemination of materials such as an information pack on "Violence Against Women: a priority health issue" and other advocacy materials.
- *Guidelines and training materials*, to improve the capacity of policy makers and health workers at all levels to identify and respond appropriately to women experiencing mental/emotional, physical and sexual abuse.
- *Public health interventions*, including a review of the published literature leading to the promotion of successful interventions to reduce violence against women.
- *Collaboration*, including working closely with women's NGOs focused on violence, UN agencies such as UNICEF and UNFPA, the Special Rapporteur on Violence against Women and research and other institutions.

Abstract: 6

Training of medical practitioners in management of victims of torture and violence

Jagdish Sobti
Communication Centre
New Delhi, India

IMA-AKN Sinha Institute have conducted a survey of 4000 doctors in 1995-6 on "Knowledge, attitude and practice of physicians in India concerning medical aspects of torture." Analysis from the questionnaire revealed the need of a training package for doctors who have to manage and treat torture victims. After discussion, a post-graduate certificate course in "Management of victims of torture and violence" was started.

Distant learning: 376 people have enrolled for course. 270 completed the course.
Analysis: Those who completed the course were sent a questionnaire. I would like to reveal with special emphasis on how this course helped them to be able to treat the victim better.

Abstract: 7

Violence as experienced by sex workers in Thiruvananthapuram: Evolving strategies for resistance

Dr. A. K. Jayasreee
FIRM
Thiruvananthapuram, India

The form and nature of violence experienced by sex workers differs from that of housewives. More than 90% of female sex workers experience one or other forms of violence frequently. Frequency, prevalence, nature, and severity are more in case of sex workers. It includes violence from state agencies like police, from caretakers and clients, violence among themselves and self harm.

Violence inflicted by state and men are characteristics of power relations in a patriarchal society. Sex workers, being victims of the double standard of morality and the most powerless section among women, use deliberate self-harm and harming their co-workers as survival strategies. Though gender violence take different shapes in different groups of women, all forms of violence in a gendered society are varied manifestations of the same etiological origin. Domestic violence experienced by housewives is yet another manifestation. Hence, strategies for resistance should be conceived as part of deconstruction of gendered identities formed in a male dominated society. It should become part of questions raised around other gender issues.

Group activities of women can be a strategy to regain lost self-esteem and identity. Self-assertion of women in the societal level should enable them to construct a new gender identity in the psychological level also. Submissiveness to violence, learned helplessness and violent reactions should be replaced by activities for gaining rights and assertive behaviour. These changes will be reflected in all institutions including health services, and the reconstruction of these becomes inevitable to accommodate the new gender identity.

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Abstract: 8

Human rights violation: A challenge to the medical profession

Jean Hald Jensen
RCT
Compenhagen, Denmark

Doctors are admonished, both by ethics and by law, not to participate in actions harmful to the health of human beings. Nevertheless, doctors have at all times participated in human rights violations. The issue of doctors' participation in human rights violation was hardly noticed as an ethical challenge before the 1970's. To-day, we recognise the problem and the fact that proving it is complicated.

Doctors may take part in these violations in several ways, and it is increasingly recognised that human rights violation could not have been extended to the degree it has to-day without the complicity of the medical profession.

There are several ways to deal with doctors as perpetrators. This may be on an individual or a collective basis. Preventive measures to prevent medical participation in future acts will be discussed.

Abstract: 9

Working children: Our cencern

Jisha Rose
CMCH
Vellore, India

This paper comprises of a few profiles of working children and an analysis of the cause, implications of Child labour and a few practical suggestions towards the mitigation of the problem.

Abstract:10

Violence against women in the family Failure of medical care to recognise victims

Jonathan David
CMCH
Vellore, India

This paper uses case histories to discuss the violence against women in the family setting, the difficulty of victims in accessing care and the failure of the medical system to recognise affected women. It will suggest strategies to help heath carers to recognise victims and improve treatment provided to them.

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Abstract: 11

Suffering in silence
The experience of women living with HIV infection

Joyce Rajan
CMCH, Vellore, India

The presentation is based on experiences as a social worker looking after women living with HIV infection. Using case histories, it will discuss the tremendous stress that women undergo. In most cases, women are unknowingly infected by their husbands and are often not told about their or their husband's illness. Apart from their physical ailments, they have to care for their ill husbands and children, cope with financial difficulties, stigmatisation by the family and the experience of being a young widow. The experience of caring for these women will also be discussed.

Abstract: 12

Trafficking in women
A serious violence against women: A Nepalese context

Kamala Adhikari
WOREC, Kathmandu, Nepal.

Trafficking in women and children is a serious problem in Nepal from the socio-economic, ethno-cultural, gender and human rights perspectives. Trafficking in women and children has been prevailing in one form or the other in the world since the evolution of human civilisation. The 104 years of autocratic Rana regime has been found the most responsible for the growth of trafficking in women and children in Nepal. Afterwards the effect of globalisation of open market philosophy expanded the demand for cheap female migrant labour in the service sector in the developing world. Consequently, women and children are exported (trafficked) outside the country and their labour is often exploited and frequently abused.

WOREC has been working against trafficking in women for the last 7 years. In 1993 and 1994 the centre conducted a situation analysis of the Nepali girls trafficked into prostitution in different brothels at Mumbai. That study revealed the information about the ethnic composition, health and living conditions of the trafficked girls in the brothels, which reminded the slavery like practices, and conditions. Besides, WOREC has been conducting advocacy and networking activities in various levels.

This paper is based on group discussions and individual interactions in the community levels, with the social workers of NGOs and the victims of trafficking. It presents the definition, elements of trafficking and the impacts of trafficking in Nepalese context. The elements of trafficking include the causes, the trafficking sites, the traffickers, the high-risk areas, the strategies used by traffickers and reasons for trafficking. These elements are suggested to be addressed by a well designed research programme, which has so far been lacking. The issues of girl trafficking are often lost or confused with the issues of prostitution and migration. In fact, prostitution is only one of the various reasons of trafficking.
The paper consists of conclusions and suggestions. The trafficking in women is a disgrace on human civilisation and a serious violence against women.

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Abstract: 13

Human rights of the victim of Chernobyl and Bhopal

Larisa Skuratovskaya
Galina Drosdova
Zossia Anisimova
Women Doctors Association
Moscow, Russia

Twelve years after Chernobyl and fourteen years after Bhopal disasters, we still haven't all truth

The International Medical Commission and Permanent People's Tribunal had series of hearings. First of which was specifically dedicated to the Bhopal Disaster (Bhopal, 1992). Second to the Industrial Hazards and Human Rights (London, 1994). And third to the Chernobyl: Environmental, Health and Human Rights implications (I have the summary from last session and ready to share with you). The verdict: the violation of the rights of the victims of "accidents" to life, information, compensation was explicitly seen as the expression of the broader and deeper aggression which has waved its least protected members by a society which respect economic interests much more than fundamental human rights. In the Session dedicated to the Violation of the Rights of Children (Naples, 1995) the fundamental rights of those who represent the future of humanity, recall very closely the scenario of the Chernobyl disaster. In Chernobyl disaster the reproductive rights and possibilities are directly threatened and severe childhood morbidity has broken the barrier of silence and denial which had appeared to be the rule on the official international scene. All information from the Sessions had been sent for the attention of the UN.

The Constitution of Russian Federation guarantees the rights of citizens for health and information was adopted in1993. The Law of Russian Federation on "Social protection of citizens, affected by radiation as a consequence of Disaster at Chernobyl AES" was adopted in October 1995. The enforcement of several development programmes was meant to show that the State value people's fate. Due to the low financing, neither the law nor the programmes are being enforced....

More and more people around the Globe have become involve for the protection of health and Human Rights. On October 3, "The Tennesseans", newspaper from State Tennessee had published Special Report from a team of journalists which had interviewed 410 people in 11 States of USA. It detailed respiratory, neurological and immune system problems their doctor cannot explain. Many of the ill persons, both workers and residents, suspect their health problems stem from poisons originating at the nuclear weapons sites. The Government of USA has established a special Commission to investigate these cases. The Health Professionals and activists for the Health and Human Rights will watch step by step for their job.

We support the idea to appoint the Special Repporteur on Health and Human Rights under UN. We are sure the time has come.

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United Nations:

Nowhere in the Universal Declaration is there an exact specification of victim's right to public truth. Such a right may be impacted in various parts of the Declaration. Such as in Articles 6, 8 and 19, which speak of the right of all to "a fair and public hearing" of any criminal charge against them, to "recognition everywhere as a person before the Law ", and to "effective remedy by the competent national tribunals for acts violating fundamental rights granted by the constitution or by Law". The International Covenant on Civil and Political Rights echoes the same languages. Its Article 2, 3a comes closest to the matter at stake when it calls for "an effective remedy" for a violation of rights "notwithstanding that the violation has been committed by persons acting in an official capacity". Then, Article 2, 3b immediately calls for the effecting of this right by "competent judicial, administrative or legislative authorities, or in the absence of such competent authorities an aggrieved person has the right "to develop the possibilities of judicial remedy". This is promising language. But only the latter words ("to develop the possibilities") speak about the condition of many people around the world today seeking to recover from vast crimes of "judicial, administrative and legislative authorities" who all together are locked in an oppressive system that not only violates Human Rights of citizens but has the power to cover up all public traces of the violation. The time has come for some specification of the rights of those citizens to begin the development of a just political system by the exercise of a right to have the story of their unjust suffering made public for the first time after the ravages of state tyranny.

It is ordinary for the law to say that victims of crimes should be compensated. It is rare indeed for the government to hold themselves responsible for publicising their own crimes and the crimes of their predecessors, or to support a system that will encourage citizens to hold all governments accountable for such crimes.

Abstract: 14

The violence of imagination
Development as the mafia of the mind

Lester Coutinho
University of Delhi
New Delhi, India

This paper argues that violence is inherent in the dominant development model. Development is not a mere economic term, but is an intimately intertwined in complex social and political realities. Taking the case of the Sardar Sarovar Project in Gujarat, the paper tries to outline how the terms development, displacement and rehabilitation constitute a hegemonic discourse that allows for the emergence of practices of violence which, in turn, allow some sections of society to govern others. The discourse of development affords the setting up of domains in which true and false are distinguished; objectification takes place and transforms human beings into subjects who are defined by the superior knowledge of the development expert, the state and its agencies. By distinguishing what may be called scientific from what may not, by connecting the science and the knowledge of the expert (State) to power relations that define, maintain and legitimise development as a superior form of knowing (knowledge), development becomes a regime of truth which then functions like the Mafia of mind, forcing itself upon the human imagination so that entire societies constitute reality and conceive of their destinies in only a

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particular way. Development cripples the human imagination to trust anything different from development creedos and prescriptions of expert knowledges.

I shall attempt to show how in the case of the Sardar Sarovar Project, the Gujarat government has produced a universalizing discourse which has defined and constituted the identities and destinies of entire human communities. Through its claim to a superior form of knowledge, the State has tried to establish an inseparable link between the level of civilisation and the level of production. It has appropriated power to represent the displaced communities, taking away from them the agency of their own histories.

Finally, in this paper I contend that in as much as colonial constructions of the uncivilised world, the underdeveloped world and the third world influenced people's self perception (a colonisation of the mind), the hegemonic discourse of development as articulated in the context of mega-projects like SSP has attempted to produce a self-perception of abnormality. The deployment of various strategies of development are thus an act of violence against imagination for they first produce the abnormality of underdevelopment and then attempt to remedy these through specific practices.

Abstract: 15

Everyday life in a 'female ward' of a prison

Mahuya Bandyopadhyay
University of Delhi
New Delhi

In documenting the nature of violence in the 'female ward' of a prison, this paper unravels the levels of violence that operate in the everyday life of a prisoner community. Within the prison system prisoners/offenders are defined and treated as perpetrators of violence. This paper seeks to elaborate the everyday life of prisoners not just as perpetrators but also as victims and survivors of violence. They are victims and survivors in two senses: firstly, simply by virtue of being within a repressive state agency and, second, by their self-image as victims (as revealed through their life stories) of their circumstances of injustices of society at large or of more tangible realities.

Conflicting identities and self-images, so prominent in the life-stories will be combined with accounts of specific incidents of violence observed by me as a fieldworker to present an anthropology of violence within prison walls. The context within which this violence occurs will be described simultaneously. The prison as a state agency perpetuates two kinds of violence. One is linked to the very aim of the penal machinery. The rhetoric of retribution, punishment and deterrence demand a certain level of severity that the system has to adopt and perpetuate in dealing with an offender. The other kind of violence is not, theoretically speaking, part of an overall rational plan of governance; rather it is very often an unplanned consequence of the way in which the system functions. This form of violence creeps into the system and operates in the day-to-day functioning of the prison in a way that its everydayness makes it seem like a legitimate part of system.

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I have two reasons for choosing to write about this; one is the penal system in our country does not give any importance to the mental health of offenders and hence health care professionals and services owing to bureaucratic hassles have not made much of a foray in this area of work. Second, the practices of the penal system are in disjunction with its philosophy - which is to make better individuals out of offenders and to ensure that recidivism does not occur.

Abstract: 16

Prevention of torture
Some threads between theory and realities

Marina Staiff, M.D.
ICRC
Geneva, Switzerland

The word prevention has become increasingly fashionable during the last one or two decades, and especially so the concept of prevention of violence. However, the great majority of actions and activities addressing violence, and torture among them, still tend to concentrate mainly on help to the victims and denunciation of the abuses. Denunciation of torture is of course of great importance, however the central question, which arises, is how to try to reduce at the root the risks that torture is practised and utilised. When there is torture, this means that many other things don't work in a given society. The paper does not have the ambition to propose any organised theory or concept of what a strategy of prevention of torture should be. Different theories exist. Its aim is merely to address a few facets of the question, which call out to doctors and particularly psychiatrists. It addresses first a few of the legal loopholes which are of concern for doctors, then it stresses the need for a real accurate "diagnosis" of the phenomenon of torture and, on the basis of this analysis, the need to build an interdisciplinary approach and a dialogue with the authorities. Some possible "slippery slopes" in such a dialogue are outlined, notably those untoward attempt to "humanise interrogations" which totally overlook the psychological dimension of torture. Finally, the need to question the admissibility of confessions in criminal procedures is suggested.

To conclude, the best prevention against torture is a society which allows space for "regulating mechanisms" to develop and to effectively function. The medical community is in a privileged position to concretely take on itself the role of one of these regulating mechanisms.

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Abstract: 17

Experience of domestic violence By Community Health Volunteers (CHVs) in urban slums

Medha S. S.
ALERT-INDIA
Mumbai, India

The paper will present the case studies of domestic violence experienced by Community Health Volunteers (CHVs). CHVs are community women, residing in the same community to whom they are supposed to reach out to and enhance their participation in health care and health promotion. They are well respected and honoured by people in their own community. However some of them are the victim of domestic violence in their own family.

The paper will unfold four different life stories of women (CHVs) who were victims of wife beating, sexual assault, physical and psychological harassment etc. Some of them are the sole breadwinners of their families; but they feed themselves with left overs. Their own health receives least care by themselves and their families, moreover the physical and psychological violence deteriorates their health further. Their experiences brings to fore the irony of our community health work and the health of the community health volunteers.

Abstract: 18

HIV/AIDS and women's rights

Meena Sheshu
SANGRAM
Sangli, India

In 1990, the World Health Organisation estimated that out of the 8 to 10 million people infected with HIV in the World over 3 million were women. And the rate of infection is increasing rapidly. It is also estimated that the number of infections among women will equal and overtake that of men. Women are being infected at a much lesser age than men on an average almost 10-15 years younger than men.

There is no doubt that women are more susceptible to infection and that they are more likely to be infected by a single act of intercourse with a partner who is infected by a sexually transmitted infection. The problem is the under reporting of the number of cases, mainly because the infection is mostly in symptomatic and also because women do not have access to services that are affordable or sensitive to their needs. There are numerous factors that can be identified as contributing to the increasing rates of infection in women.

The problem has its roots in the social and economic context of the lives of women in developing countries. Lack information, differential access to health care concepts if personal modesty, and an ignorance of the real needs of women. In the case of young women the major influential factor is genital infection and trauma caused by the incidence of Sexually Transmitted Infections (STI's) frequency of intercourse, sexual practices, male/female age differences in sexual relationships, women's nutritional status, and the presence of lesions,

inflammation and scarification in the female genital tract from causes other than STI's mainly after the birth of the first child.

In Sangli, one of the major factors for young women getting infected is marriage. The incidence of HIV infection neo-natal women is as high as 6% (Sangli Civil Hospital Study). Most of these women hear about HIV only after the routine tests performed at the clinic. They are not told – much less counseled regarding their status, and it is left to family members to explain to them the reasons for being rejected by the doctors, who will not treat HIV positive women.

There are many doctors who do not treat Persons Living with HIV. HIV Positive patients have no reasons but to visit the Government hospital which has no drugs or beds to deal the influx. Hospital staff fear the virus and refuse to provide care to patients who are infected. Given the status of women, the trauma of being infected by the virus increases manifold. The trauma of the first pregnancy (in most cases) in an alien environment (the in-laws house) coupled with the doctor's unexplainable rejection is the fate many young women have to bear. There is no record of what happens to such women. Families are not equipped to deal with their agony. The pain and anger they experience are suppressed and they are pressurized to believe in the inevitability of their unfortunate fate.

Within this milieu, it is very important to discuss the rights of women, the policy of the government, the ethical and legal issues that affect positive people and also help create a space which can be used by women to help fight their cause.

Abstract: 19

Social disaster through sexual assault on tribal women

Dr.Milan K.Dinda
SID
Calcutta, India

Distorted forms of socialisation, rather, lack of proper socialisation are responsible for different forms of violence in the society today which are of very serious concern. Sexual assault on especially those who are left behind, is a very common phenomenon. This kind of violence leads to a social disaster like a class conflict between tribal and non-tribal population in a very harmonious society. Because of pastoral nature of tribal (Santals), they are really left behind and used to face different violence including sexual assault. The long association of the author with tribals, helped to find out different discriminations which are very serious factors for social disaster.

On the basis of author's experience as the counsellor, the author would like to share his experience as well as would like to recommend some preventive measures, as well as some points on caring components for survivors.

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Abstract: 20

Custodial violence
Medical and legal perspectives

U. Nandakumar Nair
Medical College
Calicut, India

Custodial violence is a growing menace in the Indian Society. Semantic issues do exist, especially in the meaning of the term 'custody' or in the definition of torture. Despite this, our legal system is slowly getting live to this important deprivation of human rights, (ref AIR 1997, SC.610). Accordingly the evolution of 'custodial jurisprudence' as a separate branch is conceived. Para 28 of the paper proposes addition of 114-B to the Indian Evidence Act through parliamentary initiative. In the present papers, the author examines the medicolegal domains. Macanky's IPC obviously does not treat custodial violence as a separate entity. The precept of the IPC that custodial trauma is just another injury occurring in a one-to-one situation strikes at the roots of social sensibilities of a civilised society. For, this presumption does not consider the altered hierarchical relationship between policemen and their victim, the object depersonalisation, destruction of empowerment, and sheer helplessness. While these aspects call for appropriate revision of IPC, changes should also occur in the conceptual framework of medical profession, which encounters victims of custodial trauma.

Changes are needed in the manner in which torture victims are seen in a medical facility. The physician ought to prepare an especially neutral medical / accident reports to the magistrate maintaining confidentiality. Empowerment of doctors through statutory corrections in procedures is essential. Medical training must include custodial jurisprudence. Instead of committing the entire subject to Forensic Medicine, relevant portions have to be distributed among Medicine, Surgery, Psychiatry, Rehabilitation etc.,

Two recent cases are also considered:
Police men involved in custodial killing of Jose Sebastian attracted capital punishment in the trial court itself - the first of its kind in India.
Death of a naxalite leader in Feb. 1970 has attracted media attention in 1998, as one police officer made a confession that he shot the naxalite dead under orders from above.

Abstract: 21

Views and experiences of the manifestations and impact of communal violence in Mumbai: A community perspective

Nasreen Contractor
YUVA
Mumbai, India

This presentation will describe the context of violence, its manifestations and the response of the health profession and services as experienced in a slum community located in Jogeshwari East, a suburb of Mumbai, India. The population of this community is about 40,000, with the majority being Muslim households. This community is unique in the sense that over a span of

three decades this community has experienced periodic riots that have impacted the social, economic and political fabric of the community.

In the presentation I will first cover the profile of the community in terms of various dimensions, namely the socio-economic profile of its residents, the political history of the area and its history of communal riots. The resultant demographic profile, coupled with its complete lack of services, render this community highly vulnerable to violence and the access of its residents to health facilities. The inadequacy of facilities is true to several other communities in Mumbai and is indeed the case for the entire city. But what this presentation will seek to highlight are the serious consequences of inadequacy of services coupled with inaccessibility at the time of crisis that the residents of this community face.

In the second part, I will cover the manifestations of violence by describing the impact that the communal riots have had on residents. The impact is described both in terms of its physical manifestations (injury, death, destruction of property) as well as its socio-psychological manifestations. This will be further detailed out to describe its impact on women, children and youth.

In the third part I will present actual experiences recounted by residents of their attempts to seek medical help during the time of crisis. These experiences highlight not only inadequacy but non-responsiveness and outright callousness that was exhibited by a communalised health system, police force and the environment as a whole.

The presentation will end with a depiction of the present social climate of the community and its views about the health system specifically and the environment as a whole.

The material for this presentation is gathered from two documents; Planned Segregation and Report of a Rating Exercise on Public Services, as well as through interviews that were recently conducted with members of a youth group that has been working in the area for several years and some of the victims of the riots.

Abstract: 22

Mental Health Concerns of families affected by terrorism

Niraj Seth
Rajiv Gandhi Foundation
New Delhi, India

The presentation is about one of the RGF projects wherein over 800 children are being supported who have lost either one or both parents in an act of terrorist violence. These children belong to different States, including J&K, Punjab, Andhra Pradesh, Manipur, Assam, Tripura, and Nagaland. The project is being coordinated from Delhi with project partners in all these States.

It is called project INTERACT. The acronym stands for An Initiative To Educate Rehabilitate and Assist the Child victims of Terrorism. Financial assistance is being given to the children to complete, at least, their schooling. They continue to stay with their surviving parent and go to the local schools although they are encouraged to take admission in good schools with hostels. The project goes beyond the scope of simply providing them financial assistance. Though difficult to implement due to constraints of distance and limited assistance available in the form

of non-government organisations working in the area, RGF tries to give a personal touch to the children – through bringing out a newsletter, sending them birthday cards and inviting some of them to Delhi for get together. RGF has project partners who help in monitoring the programme – disbursal of cheques, organising programmes at the local level and identifying cases requiring special intervention.

It was through these limited interactions, it was realised that the children and specially the surviving guardian – mostly mothers - have their mental health concerns which need to be addressed to. At least 10% of the children we interacted with, were showing psychosomatic symptoms. Many children also shared that their mothers were going through a lot of stress. Causes for this are many - social, lack of family support, financial constraints and their own state of mind. The stress of surviving parent gets transmitted to the child as was found in many cases where the children were undergoing anxiety.

Therefore RGF has initiated a programme wherein 2-3 day long workshops are being organised for the INTERACT children and their guardians. They come and stay together at a place where counseling experts hold the sessions. ***Two such programmes have already been organised in Punjab about which some details will be given in the presentation***. RGF intends making these as regular programmes for the victims of terrorism. We do have an infrastructure through which help can be given to victims of terrorism residing in remote areas of the States mentioned earlier and we are looking forward to networking with the professionals engaged in area of mental health so that we can provide meaningful interventions to these children.

Abstract: 23

Violence and minority/majority syndrome
Its implications for plural society

Ranu Jain
Ruchi Sinha
Tata Institute of Social Sciences
Mumbai, India

Discourse on identity is a discourse on socio-cultural dynamics relating to historical legacy and existing structures. The identities of minority and majority have reference to power hierarchy in group relationships. Hence, they are essentially learnt during one's life experiences with "us" and the "others". Adherence and reactions to violence culminating in ethnically legitimised moments contribute directly towards this process of minoritisation and majoritisation. Exposed to its fascist features, victims of ethnic violence react strongly to the existing structures, either accentuating or building bridges across them. Immediate reactions to the damaged psyche of the victims may further strengthen or weaken this process of minoritisation/ majoritisation.

The socially acceptable role of medical professionals by virtue of their being "healers" is significant at this juncture as it directly addresses the essential need of "survival" and "battered faith in humanity". In short, a positive intonation by the health professionals can reinstate faith in humanity breaking the process of formation of insecure/xenophobic ghettoisation. On the other hand, a negative contact may further reinforce the process.

The paper attempts to explore the battered psyche of the victims; its impact on the group formation and example set by the medical professionals in the past.

CEHAT, Mumbai, India

Abstract: 24

Violence against women: Paradoxes

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Women and the state has been on the agenda of women's movement. The callous attitude of the police towards women in dealing with issues of dowry and other custodial enquiries is alarming and are the important concerns of progressive women's forums. Loaded with investigative and executive powers the police are unwilling / unable to implement progressive laws that are intended to aid women victims. The all-women police stations established at district levels suffer from lack of pro women perceptions. Shifting responsibilities, imposing moralistic values further perpetuate the status quo and thus negate and cause damage to the women's rights issues. Custodial torture of poor women has been on the increase. Case studies will be presented to elaborate the points stated above. Policing the police has been a time consuming activity and hampers the women's movement.

Abstract: 25

Sexual coercion and PID in slum women of Mumbai Implications for role of the health care provider

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Violence against women is perhaps the most pervasive yet least recognised human rights abuse in the world. The work of women in pro democracy movements in Latin America and parts of Asia helped to position violence against women in the international public policy area as a human rights issue. Women who were part of the pro democracy movements realised that the violence that they faced, often in domestic spheres, was invisible in the framework of human rights. This stimulated the international women's movement to push the definition of human rights to include gender based forms of violence, namely, domestic and sexual violence.

Gender based violence is also a profound health problem. At the most basic level, violence affects women's bodies and psyches throughout their life cycle. Ill health is a direct consequence of violence. Violence is an abuse of power relations between men and women. If reproductive health aims to empower women, programmes must address violence against women. Violence takes away control over the body, thus violence against women must be incorporated into its definition.

This paper examines the data from a research study on Pelvic Inflammatory Disease among slum women in Mumbai. The data was primarily of women who approached the health care facilities of the Brihanmumbai Municipal Corporation for mainly curative services. Study

women were recruited at Lokmanya Tilak Municipal General Hospital (Ward F/ North) and most controls from Mahim Maternity Home (Ward G/ North) and F/South Post Partum Centre. 240 indepth interviews were conducted with women about their experience of gynecological problems. The sexual relationship between husband and wife was an important part of the interview process.

Analysis of the data around sexuality issues and relationship with husbands revealed that, at one level, women experienced feeling supported and trusted by their husbands They also described the concern exhibited by their husbands towards their illnesses. At another level, women spoke about how men exerted control power over them. Descriptions of sexual coercion were vivid. The women also stated their expectations of the health care providers. Findings from the study related to the above issues will be discussed.

The final section of the paper will discuss the implications of the findings for the health care system. It will make a cause for violence against women being recognised as a health issue and explore the role of the health care providers at various levels of the health system in dealing gender-based violence.

Abstract: 26

Ethical dilemmas
Research on female infanticide and feticide

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The ethical dilemmas the author has faced over 12 years of work on female infanticide in the South and on feticide in the Northwest India are discussed. Till early nineties there was denial of the existence of infanticide in Tamil Nadu by the Government and academics in general.

Over the past 6 years, foetal sex determination clinics have started appearing in many Tamil Nadu towns. Following the acknowledgement of infanticide in 1992 by the State Government, it has resorted to repressive practices such as arresting mothers of infanticide victims. Well over 50 cases have been filed against poor families. Contrast this with the fact that not one case has been filed against doctors for violating the "misuse of the sex determination Act" (1994). The increasing popularity of sexing foetuses in rural Tamil Nadu is still not recognised by the Government. NGOs do not appear to be involved in monitoring the spread of clinics or the utilisation of sex determination tests. Lack of vision by donors and even disregard to ethical obligations have hampered systematic long-term work in this area.

A dilemma in undertaking large-scale studies of the incidence of feticide is that the very enquiry on the practice itself causes considerable aggravation of guilt of women in areas where the practice is rampant. We have witnessed intensification of son preference in rural North-West India. Their families are increasingly testing the first pregnancy. Modern reproductive technologies like prenatal genetic diagnosis are now abused for sexing foetuses in India.

Advertisements for these sophisticated tests are used by private practitioners to circumvent the existing law banning misuse of classical methods -ultrasound scanning, amniocentesis for sex determination.

CEHAT, Mumbai, India

Abstract: 27

Violence and survivors: Role of a nurse

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The purpose of this paper is:

1. To discuss and understand violence and care of survivors as public health problem.
2. To discuss the role of the nurse in care of survivors of violence.
3. To analyse data base to find out knowledge of staff nurses and their experiences while caring for the survivors of violence

- *Definition of nursing, Violence and its perspectives to nursing care:* Concept of violence and community health nurse; factors influencing violence and nursing care; Epidemiological approach and nursing care of survivors of violence; Application of levels of prevention.
- *Scope of nursing care in care of survivors:* Goal of nursing care; Purpose of involvement of nurses; Nurse's tasks and roles; Nursing practice and future directions.
- *Data Base analysis:* "To identify preliminary knowledge and experiences of staff nurses in relation to care of survivors in different settings." This brief study (survey) was conducted by the writer of this paper between months of September to October 1998. Sample was about 50 staff nurses of various hospital settings. Analysis of data in percentile would help to put practical suggestions to plan and organise short training programme and curricula of nursing faculty.

Nursing, as a predominantly female profession and as a discipline based on holistic and client based theories and models is ideally suited to understand the needs of survivors of violence.

Abstract: 28

Where women are guinea pigs

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New Delhi, India

Helsinki Declaration. Basic Principles para 5: Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison to foreseeable benefits to the subjects or to others. Concerns for the interests of the subject must always prevail over the interests of science and society.

ICMR Guidelines, February 1980: Although the procedure of obtaining the signatures of the person giving his/her consent cannot be dispensed with, at the same time, it must be emphasised that in the context of the conditions prevailing in the country, mere signatures would not ensure the requirements of informed consent...the proposed participants in a clinical research programme should be made aware, by a person not in a position to influence the

patient such as a treating physician but for example, by a social worker, of the fact that a new drug or procedure is being evaluated.

Natural history of precarious and early cancerous lesions of the uterine cervix, Usha Luthra et al, Acta Cytologica, May-June 1987: A formal informed consent in writing from subjects included in a study is not standard practice in India.

Recently in Delhi, the Institute of Cytology and Preventive Oncology (ICPO), a body under the Indian Council of Medical Research (ICMR), carried out a study of the rates of progression of uterine cervical dysphasia to malignancy. As part of the study they selected 1158 women between 1976-88 with varying degree of cervical dysplasias for long term follow up. The project explored how growth at times turns malignant or disappears without treatment.

While the project was being carried out, none of the women were told that their tissue growth had turned malignant. So, despite the fact that a simple surgery could have removed the cervical lesions, the women were not given any medical feedback, further treatment or reference. The result was, nearly 62 women developed cancer and in 9, the cancer spread to the other parts of the body. 5 women died.

Women s groups, NGO s, concerned doctors and individuals are questioning the ethics of the study carried out by the ICPO. They are shocked that even after abnormal tissue growth was detected and the risk of cancer identified, the doctors did not think it fit to treat the women, but chose instead to use them as guinea pigs for their experiments.

On the Human Rights Day (10th December 1997), the representatives of the above groups stormed into the ICMR to lodge their protest against this unethical and inhuman research. After a heated debate ICMR agreed to discuss the issue after a week. In the meeting the issues of informed consent, treatment options, follow up, right to compensation and the ethics of the study were questioned.

The paper where women are guinea pigsý presents the details of the debate between the ICMR and the concerned women s groups and activists. The paper also looks into the larger issues of medical ethics, role of medical professionals and human rights.

Abstract: 29

Corporate violence and abuse of human rights The Union Carbide disaster in Bhopal: A case study

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Much of the concern over violation of human rights has been focused on those committed by government agencies. In comparison, routine and gross acts of human rights violations of Corporations have attracted little attention and much less remedial action. Substantially large number of transnational corporations today exert direct control over populations far larger than those under national governments and are in control of moneys far exceeding national incomes. The routine abuse of corporate power is manifest in the violations of human rights of workers

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employed by the corporations, factory neighbourhood populations and voluntary and involuntary consumers. Yet, appropriate national and international legislation and agencies to ensure remedial action against corporate abuse of human rights are close to non-existent.

The December 1984 Union Carbide disaster in Bhopal illustrates these lacunae in a profound sense. In describing the crimes being committed by Union Carbide, a US based transnational, this paper calls for greater attention and concern towards the unending aftermath of the disaster by the community concerned about and active on issues of human rights violation.

Abstract: 30
Hearing the unsaid

Shalini
Tarshi
New Delhi, India

The paper is based upon the calls received on a helpline on reproductive and sexual health issues. TARSHI, a Delhi based helpline works towards enabling people live lives of dignity and freedom from fear, infection and reproductive and sexual ill-health. Violation of women's sexual rights is one of the greatest challenges we are continually confronted with in this effort. This violation manifests itself in issues of consent, contraceptive choices and responsibilities, sexual health rights, and the right to enjoy safer sex with dignity. Besides these rather obvious aspects, the extent to which a woman's sexual rights are withheld and/or violated also depends indirectly upon some other factors. These include her social status, self-esteem, and the social psyche with its ignorant, and often dangerous beliefs about women, their sexual rights, and sexuality in general.

Abstract: 31
Medical Violence

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"Violent" means to violate, to cross over some boundary in a not so pleasant way, with a manipulative objective. Medical people – those who preach medicine in any form - are considered "healers". Apparently, these two terms, healing and violating, do not go hand in hand. This paper looks at some instances of medical violence, the damage it can cause in terms of terror, unresolved disease or death and tries to bring out some of the causative factors and justification for the same.

Abstract: 32

Police firing on unarmed workers, Bhilai, 1992

Sheikh Ansar
Binayak Sen
Chhattisgarh Mukti Morcha
Raipur, India

On July 1, 1992, police fired on a peaceful demonstration of unarmed workers, including women and children, squatting on the rail tracks outside Bhilai railway station in pursuit of their constitutional right to form trade union. Sixteen people were killed. This incident illustrates the violent and totally unregulated nature of the kind of industrialisation that the Chhattisgarh region is undergoing. The repressive nature of the state ties up in this situation with the unregulated interests of capital. The incident, its antecedents and the response of the people's organisations are discussed in this paper.

Abstract: 33

Human rights aspects of nuclear technology

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This paper examines the different ways in which nuclear technology has caused suffering to people. Starting with Hiroshima and Nagasaki, it will discuss the health effects of nuclear testing in the Marshall islands, the effects of nuclear reactor explosions highlighting the Chernobyl accident and then go on to uranium mining at Jadugoda and the effects of the Indian Nuclear programme on the people of our country. It focuses on the human rights violations of nuclear technology and also discusses the World Court project against nuclear weapons.

Abstract: 34

Preventing violence in indoor patient Role of a nurse teacher

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This paper is based on the experiences and observations made during the last 32 years of my clinical practice in rural hospitals and medical college hospitals. This paper includes:

(1) An introduction to violence, (2) Definition, (3) Type of behaviour observed, (4) Common factors initiating violence, (5) Effects of violence in caring patients.

Role of a nurse teacher broadly in three categories: (1) Instructional roles, (2) Faculty roles, (3) An individual role.

While playing her role, especially instructional role; she helps students to inculcate attitude to use nursing process approach and prevents events which might stimulate violence. She develops such skills to minimise effects of violence in indoor patients. So that individuals approaching hospitalisation receive experience to get influenced and to take this task to their home and community as a whole.

Abstract: 35

Discrimination of women in the HIV/AIDS context

Sushila Mendonca
RISHTA
Goa, India

Vulnerability of women

During the initial stage of the HIV epidemic, homosexuals and I.V. Drug users were the most vulnerable groups. Gradually the rates of heterosexual transmission increased. The 1990's show a clear trend of HIV infections predominant among women in poorer countries. Research studies indicate that this trend is likely to increase. The reasons for this are various viz. Biological, socio-cultural, and economic.

The Goan situation

Goa ranks seventh in India in reported incidence of HIV infection. Given the small population viz. Thirteen lakhs, the actual number of HIV positive cases is alarming and the rates continue to increase rapidly. Recent estimates show almost two new infections per day. This has led the Government, NGOs and individuals to take steps to prevent the further spread of infections and to support people already affected. RISHTA is one such organisation, formed by individuals who have been working for many years now on HIV/AIDS issues. In this paper I will focus on the pattern and nature of vulnerability affecting the women we have counselled and are counselling. The trauma that these women face is imaginable and operates at various levels. At

the same time the support from material and marital families have been varied. The forms of discrimination that these women face include pressure from parents and in- laws as well as socio-economic and legal discrimination.

The implications of women being infected are tremendous. Their role as carers and their reproductive functions have long term implications where the spread of HIV/AIDS and the role of the health care system is concerned. The issue of women and HIV/AIDS needs to be placed in a broader social and cultural context. Women's vulnerability to HIV is also increased by the inequality and discrimination in society that most often denies them access to education, health, independent incomes and property rights. These reasons have led us to believe that preventive strategies for combating HIV/AIDS require not only specific issues but also need to consider the underlying structural imbalances and the combination of physical and economic vulnerability which operate to increase women's risk to infection.

There are several ways that we have tried to support the HIV+ve women in our organisation. These include counselling, medical support, formation of self help groups, legal help, negotiating and counselling of family, contacting supportive persons and grief counselling.

Abstract: 36

Missing vital links

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VACHA
Mumbai, India

This paper is based on part of our ongoing study of girl students from socio-economically-backward class of regional language schools of Bombay Municipal Schools in the age group9-12. We have named our project Kishori to identify this age group. (Kishori in Hindi means adolescent girl.)

We want to highlight the issue of women's health, which has shifted to reproductive health paradigm. That paradigm ensures the Kishori project's age group to be left out and missed in the life span and health span of the women.

We want to establish these missing links through our case studies. Through our case studies now we have arrived at a definition of health and how we want to proceed in the future in the context of education and urbanisation processes and its influence on lives of this age group of girl students.

We want to compare the findings of our study in urban metropolis situation based school education with earlier studies of which, most serious ones are based on rural settings.

This paper is based on three schools from three areas, each having its own specificity, and that has provided a rational in incorporating those schools.

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Abstract: 37

A violation of citizens rights

The role of health sector, particularly of the state health and related services, in regard to tuberculosis in India.

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Tuberculosis (TB), a major public health problem in India since 1900s currently affects 14-17 million people (prevalence) and causes the estimated annual death (mortality) of 500,000 persons. Countrywide government sponsored anti-TB public health measures introduced in 1948, developed into the National Tuberculosis Program in 1962. Despite gains, implementation gaps between programme goals and performances over 35 years have been such that there has been insignificant impact on the magnitude of the disease problem. Poor implementation results in millions of citizens receiving inadequate, wrong and irregular treatment. Tuberculosis is easily curable at very low cost and, suffering and death due to TB is preventable. Though technology for TB drug manufacture is indigenously available, production is inadequate for the need. Inadequate drug supply in government health services, and inability to access drugs by poor patients occurs frequently. Poor TB case management due to systemic failures of the health and related services have resulted in the development of drug resistance and in an increasing number of chronic excretors who continue disease transmission in society.

Unequal societal relations affect not only the development and transmission of TB, but also the implementation of control programmes, particularly for the underprivileged, among whom high level of indebtedness due to the disease and difficulties in accessing private services have been noted.

The State has abrogated its Constitutional mandate to protect the health and well-being of its citizens by under-funding the National TB Programme by not ensuring the development of basic health services through which TB care can be provided and by not heeding the recommendations of its own specialised national TB institutions and researchers. Efforts are required by all sections of civic society, particularly the health sector, to prevent the violation of health rights by ensuring early diagnosis and completion of effective therapy so as to achieve cure. Additionally, social security and rehabilitation measures for advanced cases are required.

Abstract: 38

Rehabilitation of survivors of v iolence
From politics to practice

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In all countries where centres are being established, or are already in place, to help torture survivors, and survivors of domestic and other violence, a key issue is navigating the hostile

political and social environment, to ensure the safe establishment and survival of the help centre.

Repression by states may be directed at political and social leaders, heads of lobbying and other bodies. Where these were predominantly male the pattern of violence reflected the societal position. But the involvement by women in politics has increasingly led to their involvement as victims. This type of violence is likely to also encompass torture and other systematic abuses within prisons or other institutions.

Societal violence patterns vary from country to country. But in most it is true that men, especially young men, have the highest risk of injury or death from casual violence. This pattern is associated with cultural factors: western patterns of social behaviour accompanied by drug or alcohol ingestion, associates violence with the influence of these drugs. There is also often a linkage to criminal activity, albeit often of a relatively minor nature. Women are more often victims of random acts of violence; because they are in the wrong place at the wrong time, rather then putting themselves knowingly at risk.

Domestic violence is portrayed in the developed world, as a predominantly male on female issue; that is males are aggressors, women victims. The reality is that this is the commonest presenting pattern, but that women can also be violent in domestic and other settings. The apparent underemphasis on men as victims is now leading to a backlash which is undermining the "Women's Aid" movement. Interestingly although there is little good evidence about the frequency of female: male violence, there is no doubt that courts treat it differently. If an abused woman kills her male partner/abuser the courts usually treat her leniently; the inverse is not the case. This further fuels the "male as victim" argument. Further the concept that women may be victims of domestic violence and eventually react with overwhelming violence against their abuser has now been used so extensively in court cases that it is treated with considerable scepticism, in both the UK and the USA.

Finally the level of violence around warfare and civil unrest is considerable and no longer only affects soldiers or those who are in the front line. Wars, and civil unrest, are all fought within the normal living and working areas of populations. Civilians become indistinguishable from combatants. Women and children can become accidental and incidental victims. There is also the far more sinister fact that increasingly armies are less likely to fight according to the Geneva conventions, and use sexual violence as a tool or weapon of war. This almost always lead to women being disproportionately victimised.

At the same time societies face increasing pressures to deal with the complexities of everyday life and to survive in a hostile economic climate. The "Ergonomics" factors still hold sway with little value given to helping others, or to caring for that less fortunate than oneself. Thus the will to care for victims is low, as the cost rises. Politically it is rarely if ever seen as a vote winner, reducing still further the likelihood of financial or state support.

All these factors interact to make the positioning of support centres complex and sensitive; unless done based upon an understanding of these factors, funding and other resources will be increasingly hard to secure.

CEHAT, Mumbai, India

PAPERS

(Total: 26)

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Paper: 1

Domestic violence against women
An investigation of hospital casualty records, Mumbai

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Introduction and objectives

Domestic violence against women is increasingly recognised as a major health and social problem in India. It is also a concern for public health. Not only is violence against women widespread, deeply entrenched, silently borne, and relatively impervious to women's situation, but also attitudes uniformly justify wife beating, and few women would opt out of an abusive marriage (Jejeebhoy, 1998, Jejeebhoy and Cook, 1997). At the same time, there is a dearth of information on the magnitude and patterns of domestic violence against women in India, particularly by way of community based data. Facilty based data—from police, court, hospital, and NGO records – do exist, but these data remain scattered, poorly maintained, and seldom used.

The objective of the paper is to explore faculty based data from one source, the casualty department of one public hospital in Mumbai city (J.J. Hospital) for their insights into possible domestic violence. The intention is to draw up a profile – limited though it might be – of the patterns and determinants of violence against women, as assessed from routine hospital records. The aim is also to demonstrate that a scrutinisation of casualty registers can throw up insights into domestic violence against women, and to challenge health facilities to use (or supplement) these data to detect, and provide appropriate counselling and other services to women victims of domestic violence.

Studies based on emergency department admissions have been carried out in other settings. One study was conducted among female trauma patients at an emergency room in Philadelphia (McLeer and Anwar, 1989). Routine records in this study suggest that some 6% women trauma patients had been battered; this proportion increased to 30% after an intervention in which staff were sensitised, and new protocols instituted for identifying battered women. In another such study in Denver, injuries of 12% of women with a current male partner were attributed to domestic violence (Abbott and others, 1996). A similar study in Australia whose sample comprised women attending the emergency department only between 8 a.m. and midnight, observed that only two percent of women attended the hospital as a direct result of an incident of domestic violence, although one quarter of them admitted to having experienced domestic violence in the past (Bates and others 1995).

Major and well-known limitations of such a design (applicable to any facility-based study) are evident in all facility-based studies. For example, such studies are handicapped by the absence of a denominator, and hence an inability to indicate the proportion of women in any community who suffer domestic violence. Nor do they enable attention to community norms regarding domestic violence against women. Such studies also omit the large majority of women who

suffer violence in some form, but are not compelled by injury or desperation to seek help; in other words, these studies are restricted to women who represent "the tip of the iceberg" only; for example, one study observes that while the injuries suffered by 12% of women visiting the emergency room related to domestic violence, over half of women attending the emergency room reported that they had experienced domestic violence at some point in their lives (Abbott and others, 1996). Another concern is the limited scope and quality of data. On the one hand, few women are willing to admit that their injuries resulted from domestic violence. On the other hand, neither recording systems nor physicians recording routine admissions are sensitive enough to probe and elicit data on domestic violence; concerted efforts at developing sensitive reporting protocols, for example, effected a six fold increase in reported cases of wife battering (McLeer and Anwar, 1989).

Data

Recognising these inherent limitations, this study examines evidence from existing data from one public hospital in Mumbai (J.J.Hospital). The hospital is medium sized, situated in south central Mumbai, and caters to the relatively low income, largely mixed Hindu and Muslim populations residing in its vicinity.

Typically, the point of entry for all emergency cases arriving at any hospital is the Casualty Department. Details of all accident, injury, burn, or poison cases are, moreover, maintained in a separate register, known as the Emergency Police Register (EPR). This register records both life-threatening and relatively less serious injuries, and the patients whose information is recorded in these registers are either treated in the casualty department, or in other departments as out-patients and then allowed to return home, or if warranted, admitted as in-patients, usually to such departments as surgical, trauma, burns and OB & GYN.

Data collected in this study refer to all women whose cases were recorded in the emergency Police Record register of the JJ Hospital during the year 1996. Data drawn thus are typical of all public hospitals in the city that serve casualty cases. Only existing records are analysed, and no attempt has been made to interview women, or their families.

A well-known limitation of facility based studies is the paucity of appropriate data available from them. EPR registers typically do not contain much socio-economic data, aside from age, religion, and area of residence. But they are rich in such other information as the time of the incident, and the time at admission, the kind of assault and type of instrument used, part of the body injured, and it's severity, and the kinds of treatment received. On occasion, supplementary information – pregnancy status, or information on who accompanied the woman to the hospital – is also recorded.

Classification of injured women

A total of 833 women visited the casualty department during 1996 with a variety of injuries: assault, accidental falls, burns, and attempted suicides. This paper deals with 745 of these women who were aged 15 or more. Table 1 classifies women by cause of injury, as specified in the registers. As Panel 1 shows, almost half of the fifteen percent had consumed poison, 11% had suffered burns, and 9%had suffered a fall. The remaining 21% had suffered traffic and other accidents.

Not surprisingly, few women would, without sensitive probing and counselling, implicate their husbands or other family members as perpetrators of the violent incident. Hence, this paper has

had to adopt a fairly liberal definition, on the basis of supplementary information available in the casualty registers. Domestic violence is classified now as (a) definite (b) possible and (c) unlikely, as seen in Table 1.

Definitely domestic violence: A definite case of domestic violence is one in which the injury is clearly attributed to the husband, other family member or a "known" person. Over one in five women (22.4%) fall into this category: 164 women were assaulted by their husband, other family, or a "known" person, and three women reported that their husbands had set them on fire.

Possibly domestic violence: A possible case of domestic violence includes women who refused to report the name of the perpetrator of the incident, whether assault, or burn. Also classified, as possible cases of domestic violence are women who have resorted to attempted suicide, since much of this relates to harassment and abuse. Almost half of all women (44%) fall into this category. They include (a) 138 women who had suffered assault, but refused to give the name of the perpetrator; (b) 70 women who suffered "accidental" burns, and (c) 122 women who were recorded as having attempted to kill themselves, 112 by consuming poison, six by setting themselves on fire, and 4 by wounding themselves.

Unlikely cases of domestic violence: Falls were difficult to classify: all were reported as accidental, and hence we have classified them separately as unlikely cases of domestic violence. A total of 67 women, or 9% of all women who reported accidentally falling down stairs, tripping, and so on.

Definitely unrelated to domestic violence: Finally, traffic and train accidents, accidents occurring in the work place, as well as assaults reported to have been committed by outsiders have been distinguished as clearly lying outside the realm of domestic violence. About one quarter of all women fall into this category: 21%for vehicle and other traffic accidents, and four percent as a result of assault by outsiders.

In contrast to women, not only do more men visit the casualty department for injuries, but also, they visit for a quite distinct set of injuries. Table 2 reports on data drawn from one register, randomly, representing the first quarter of 1996. Information on a total of 159 men aged 15 or more is available. Data are classified by cause of injury, as specified in the registers. The leading cause of injury is assault by an outsider, experienced by almost two in five cases (38%). One quarter was treated in the casualty department for alcohol abuse. And almost one-third (31%) were treated for various accidents – largely traffic (18%) and falls (9%). Only 4%, compared to 16% among women, visited as a consequence of attempted suicide.

Profile of injured women

Few data is available in the Emergency Police Register on socio-economic or demographic characteristics of patients treated in the casualty department. Information on gender, religion, and age is almost always available. Other data, such as pregnancy status, and person accompanying the injured person, are less uniformly recorded, and hence cannot be analysed.

Table 3 presents a profile of injured women. The JJ Hospital serves a population of roughly 4,00,000, residing in the areas of Nagpada, Kamathipura, and Byculla. These areas have a large concentration of Muslim residents, and hence, it is no surprise that Muslims constitute 44% of women treated in the casualty department over the year 1996. What is mildly notable is that Muslims are somewhat more likely to fall into the category of deliberate assault than Hindus,

suggesting either that they are somewhat more likely to suffer domestic violence, or that they are more likely than Hindus to identify the perpetrator. In contrast, burn victims are predominantly Hindu (76%)

The age profile shows clearly that cases of definite and possible domestic violence cases tend to fall in the ages 15-39: about 80% of both definite and possible domestic violence cases tend to fall in these ages. Well over 40% fall into the ages 20-29 (45% and 42%, respectively), and this proportion goes up to 51% of all women who attempted suicide. In contrast, women who reported falls are considerably older: 58%are aged 15-39, and 34%aged 50 or more. A relatively similar age distribution is reported by women whose injuries were clearly unrelated to domestic violence.

Timing of the violent incident

Also recorded in the Emergency Police Register is the time of the incident and admission. In about one third of all cases, the time that the incident occurred has not been reported, hence we rely here on the timing of the admission to shed light on average, a delay of upto one hour between the time of the incident and of admission. Hence we may assume that all incidents that occurred between the hours of 10 p.m. and 5 a.m. will be admitted to the casualty department between 11p.m and 6a.m. Results suggest that over one in five (21%) cases of both definite and possible domestic violence occur at night, between the hours of 11p.m and 5a.m. Falls, in contrast, are less likely to occur in these hours (15%).

Description of injuries

Data recorded in emergency registers gives some idea of the extent of injuries suffered, and the ways in which injuries occurred. Table 4 describes the injuries women have suffered. Among definite cases of domestic violence, the majority (44%) was kicked, beaten, punched, bitten, choked or strangled; 19% were assaulted with a stick, rod, or other blunt instrument, and 16% with a knife or blade. Only four percent admitted deliberate burning.

Among the possible cases of domestic violence, prominent causes of injury included beating and kicking etc (34%), assault with a stick, rod, etc (23%), consumption of various poisonous substances (28%, including pesticides (12%), rat poison (8%) chemicals and sleeping pills (8%), and stove burst (15%).

Information on falls once again gives few clues that would suggest deliberate violence. The large majority report that they fell down stairs or some other height (27%) or tripped etc. including in the bathroom (58%) – given the conditions of housing in which many chawl and slum dwellers reside, these figures are not, on the face of it, surprising.

The head and face were prime targets for abuse, by about three in five victims of definite domestic violence; about two in five report injuries to the legs or arms, and only about one quarter to the body. In contrast to these findings, in-depth studies of women suggest that a prime target for domestic violence is the abdomen, and chest, parts of the body on which injuries are obviously less likely to be visible. It is possible then that there is a disproportionate concentration among women who present themselves to the casualty department of those with clearly visible injuries, most likely on the face. In contrast, burn victims are most likely to suffer burns on their limbs and bodies, than on their faces.

Types of injuries suffered were largely abrasions, contusions, and contusions with laceration among women who had suffered assault. Profuse bleeding was suffered by a notable minority of women, including 8% of the definite cases of domestic violence, and 12% of women who suffered assault but did not name the perpetrator. Of interest also is that while 13% of the possible cases of domestic violence were found to be semi- or unconscious, not a single one of the definite cases of domestic violence were – this may well suggest that if brought in a semi- or unconscious condition, statements may be more likely to under-report family violence.

A summary measure of the severity of the injury comes from the assessment of the physician. As many as 13% of definite victims of domestic violence have suffered a serious injury. In contrast, among the possible victims of domestic violence: as many as 25%of the attempted suicide cases, and as many as 61% of the "accidental stove burst" cases were assessed to be in serious condition.

Summary and conclusions

Although incomplete, inadequate, and inconclusive, data collected in emergency police registers argues strongly for greater sensitivity in recording information on domestic violence against women, and in recognising and providing sensitive counselling and referral to potential victims of domestic violence.

Results suggest that as many as 23% -- almost one in four – women can be classified as definite cases of domestic violence. They have either suffered an assault by a family member or "known person", or, in a minority of cases, attribute the burns they suffered to their husband or other family member. Another 44% of all women appear to be possible victims of violence: they have either refused to name the perpetrator of the assault (19%), or attributed the burns they suffered to accidental stove burst etc (9%), or were clear cases of attempted suicide, a measure to which women who have suffered violence and harassment are likely to resort (16%). Hence, certainly one quarter and upto two-thirds of all women reporting to the casualty department may have suffered domestic violence.

Other points that corroborate this suggestion of domestic violence include the fact that disturbing proportions – over one fifth – have suffered the injury in the late hours of the night (between roughly 10 p.m. and 5 a.m) raising further doubts about their accidental status. Age distributions of women who attended the casualty department suggest, moreover, that large proportions of these women are in the peak reproductive ages, 20-34, a period during which women have little say in their own lives.

Most of the definite cases of domestic violence occurred as a result of beatings, either by slaps, punches, and kicks, or with a stick or belt; of knife or blade wounds, or, in a small proportion of confirmed cases, as a result of wife –burning. Attempted suicide claimed 16% of all cases, and these may well have been attenuated by domestic violence and harassment. Most burn victims claimed the burn occurred accidentally while cooking; and a large proportion of women who suffered assault refused to identify the perpetrator; undoubtedly some of both these groups of women have concealed the fact that they were deliberately set on fire.

While cuts and bruises dominate, profuse bleeding, and fractures are also evident among assault cases. A disturbing proportion of women have received serious and life threatening injuries – one in eight women whose injuries have definitely resulted from domestic violence, one quarter of the attempted suicide cases, and three in five of the "accidental" burns cases, with burns over more than half of their bodies.

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Results clearly suggest that domestic violence is a serious but still invisible public health threat. Data that is routinely collected in casualty registers may merely scratch the surface, but remain at present, one of the only sources of information on the subject. Yet this data remains obscure, only to be utilised in the rare medico-legal cases. Data recorded in registers tend, moreover, to be superficial, and incomplete. And practitioners who record this data are not even trained to recognise symptoms of abuse, let alone provide sensitive counselling or referral. What is needed is for practitioners to routinely ask all women direct questions about abuse (see, for example, Richardson and Feder, 1996). Modification of recording formats has enabled considerable improvement in the identification of battered women in at least two studies (Olson and others,1996; McLeer and Anwar, 1989). The results of this study, while admittedly somewhat speculative, highlight the enormity of the problem, the need to review data collection systems and protocols, and the training of providers, and indeed, the urgent need for domestic violence to become integrated into city's public health system.

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Table 1: Types of injuries reported, adult women 15 + attending the casualty department of JJ Hospital, 1996.

		Number	Percentage
I	**Classification of casualty attendance**		
	Assault	332	44.6
	Falls	67	9.0
	Burns	79	10.6
	Consumption of poison	112	15.0
	Vehicle, other accidents	155	20.8
II	**Classification by domestic violence status**		
1	**Definite case of domestic violence: perpetrator reported**	**167**	**22.4**
a	Assault by husband, other family member, or "known" person	164	22.0
b	Set on fire by husband	3	0.4
2	**Possible cases of domestic violence**	**330**	**44.3**
a	Assault; no information on perpetrator	138	18.5
B	Burn; stove burst or other cause	70	9.4
c	Attempted suicide	122	16.4
	Consumption of poison	112	15.0
	Assault on self	4	0,5
	Set herself on fire	6	0.8
3	**Unlikely case of domestic violence**	**67**	**9.0**
	All falls, reportedly accidental	67	9.0
4	**Definitely not cases of domestic violence**	**181**	**24.3**
a	Assault by outsiders	26	3.5
B	Vehicle and other accidents	155	20.8
	TOTAL	**745**	**100.0**

Table 2: Types of injuries reported, adult men 15+, attending the casualty department of JJ Hospital, first quarter, 1996(a)

	Number	Percentage
Alcohol consumption	**41**	**25.8**
Attempted suicide	**6**	**3.8**
Consumption of poison, assault on self (b)		
Assaults	**62**	**39.0**
Assault by outsider	61	38.4
Assault by family member	1	0.6
Accidents	**50**	**31.4**
At home (burn, other) (c)	2	1.3
Fall	14	8.8
Vehicle/ train/ road accidents	28	17.6
Injury or accident at work	6	3.8
TOTAL	**159**	**100.0**

Data are drawn from one of four registers covering this period; The register was randomly selected
Consumption of poison: 5; assault on self: 1
Accidents at home: burn: 1; other: 1

Table 3: Profile of Women aged 15+ presenting in Casualty Department (EPR) by likely domestic violence status, women attending the casualty department of JJ Hospital, 1996

		ALL	Definite	Possible				Unlikely	Not domestic violence
			Assault & burn	Total	Assault	Burn	Attempted suicide	Falls	Accident, assault by outsider
	NUMBER	745	167	330	138	70	122	67	181
1	Religion								
	Hindus	52.9	41.9	57.6	50.0	75.7	55.7	67.2	49.2
	Muslims	44.0	52.7	40.9	49.3	22.9	41.8	28.4	47.5
	Christians, othrs	3.1	5.4	1.5	0.7	1.4	2.5	4.5	3.3
2	Age								
	15-19	10.1	7.2	12.4	8.7	11.4	17.2	10.4	8.3
	20-24	20.9	19.8	24.2	12.3	31.4	33.6	16.4	17.7
	25-29	18.0	25.1	17.3	20.3	11.4	17.2	9.0	16.0
	30-34	14.9	16.2	16.1	16.7	20.0	13.1	13.4	12.2
	35-39	11.1	12.0	12.7	18.8	14.3	4.9	9.0	8.3
	40-44	6.8	9.6	5.8	8.7	0.0	5.7	1.5	8.3
	45-49	4.4	3.6	3.9	2.9	5.7	4.1	4.5	6.1
	50-59	5.5	2.4	2.7	3.6	2.9	1.6	13.4	10.5
	60 and above	7.1	3.6	3.3	5.1	2.9	1.6	20.9	12.2
	N/A	1.1	0.6	1.5	2.9	0.0	0.8	1.5	0.6
3	Admission time								
	2100 – 2259	14.4	15.6	14.8	18.8	11.4	12.3	11.9	13.3
	2300 – 0359	18.3	18.6	20.0	18.1	20.0	22.1	13.4	16.6
	0400 – 0559	1.5	2.4	.06	0.0	2.9	0.0	1.5	2.2
	0600 – 1159	14.1	15.6	11.8	12.3	12.9	10.7	25.4	12.7
	1200 – 1759	34.8	34.1	34.2	38.4	34.3	29.5	32.8	37.0
	1800 – 2059	15.7	11.4	17.3	11.6	17.1	23.8	14.9	17.1
	NR	1.3	2.4	1.2	0.7	1.4	1.6	0.0	1.1

Table 4: Description of injuries, women aged 15+, by likely domestic violence status, Women attending the casualty department of JJ Hospital, 1996

		Definite	Possible				Unlikely
		Assault & burn	Total	Assault	Burn	Attempted suicide	Falls
	Number	171	326	138	66	122	67
1	**Part of body injured**		(a)			(a)	
	Head, face, eyes, nose, neck	55.6	62.1	65.2	59.1	40.0	47.8
	Head	18.7	12.6	16.7	22.7	30.0	23.9
	Face	29.2	23.6	35.5	37.9	30.0	29.9
	Eyes	10.5	6.1	12.3	3.0	10.0	4.5
	Nose	4.1	4.3	6.5	4.5	20.0	3.0
	Neck	5.3	11.3	9.4	31.8	30.0	0.0
	Chest, back, abdomen	22.8	26.4	21.7	77.3	50.0	3.0
	Chest	12.9	17.8	8.0	65.2	40.0	0.0
	Back	6.4	11.0	8.0	30.3	50.0	1.5

	Abdomen	9.9	15.3	8.0	53.0	40.0	1.5
	Arms or legs	41.5	36.8	37.0	89.4	100.0	31.3
	Arms	33.3	29.1	29.0	71.2	80.0	16.4
	Legs	12.3	19.3	8.7	66.7	70.0	17.9
2	**How injured**						
	Blunt instrument, stick, iron rod, belt, etc	19.3	10.1	23.1	N/A	0.0	n.a
	Sharp instrument, knife, blade	16.4	9.2	18.2	n.a	3.3	n.a
	Slapped, kicked, strangled, bit, choked	43.9	14.7	33.6	n.a	0.0	n.a
	Fell from height	n.a	0.0	n.a	n.a	0.0	26.9
	Tripped, fell over	n.a	0.0	n.a	n.a	0.0	58.2
	Deliberately set on fire, acid burn	4.1	1.8	n.a	0.0	4.9	n.a
	Stove burst, gas cylinder burst, accident	n.a	14.7	n.a	72.7	0.0	n.a
	Consumed rat poison	n.a	7.7	n.a	n.a	20.5	n.a
	Consumed sleeping pills, overdose	n.a	4.0	n.a	n.a	10.7	n.a
	Consumed chemicals poison	n.a	3.7	n.a	n.a	9.8	n.a
	Consumed pesticide poison	n.a	12.3	n.a	n.a	32.8	n.a
	No answer	20.5	23.3	25.2	27.3	18.0	14.9
3	**Type of injury**						
	Abrasion	25.7	14.4	33.3	0.0	0.8	16.4
	Contusion	35.7	15.6	37.0	0.0	0.0	22.4
	Laceration	3.5	2.1	4.3	0.0	0.8	1.5
	Contusion and laceration	24.0	8.9	19.6	0.0	1.6	28.4
	Fracture	1.2	0.9	2.2	0.0	0.0	7.5
	Profuse bleeding	7.6	5.2	11.6	0.0	0.8	6.0
	Semi-conscious	0.0	4.3	0.0	3.0	9.8	0.0
	Unconscious	0.0	8.3	0.7	19.7	10.7	7.5
	If burn < 40%	(b)	n.a	n.a	31.8	(c)	n.a
	If burn 41 – 60%	(b)	n.a	n.a	27.3	(c)	n.a
	If burn 61 – 80%	(b)	n.a	n.a	16.7	(c)	n.a
	If burn 81 – 100%	(b)	n.a	n.a	16.7	(c)	n.a
4	**Extent of injury**						
	Medium or serious (d)	12.8	43.4	9.4	60.6	24.6	11.9

Excludes poison cases

Of the seven cases of wife – burning, 3 received burns on more than 80% of their bodies, one on 60%-80% and one under 40%; information on the remaining two was not available

Of the six cases of attempted suicide by self immolation, 4 received burns on more than 80% of their bodies, and one on 60%-80%; information on the remaining case was not available

For poison cases, all who were semi or unconscious; for burn cases all whose burns exceeded 33% of their bodies.

Paper: 2

*Dalit*s, violence and health concerns

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The *Dalit*s of India who constituted 16.32% of the population of India in1991 (census 1991) have resorted to violence also as a means of achieving their social, economic and political rights. Such acts of violence were invariably against the oppressive caste system supported in varying degrees by the colonial state and the princely states attached to them and even by the post colonial Indian state. Very often peaceful assertions of rights by *Dalit*s met with repression by the upper caste elite and the state thus leading to violence on both the sides. This is not to say that the *Dalit*s on their own did not take to violence. The point is that institutionalised violence of the upper caste who mostly constitute the ruling classes and the violence of the machinaries of state go relatively unnoticed, whereas violence by *Dalit*s in challenging the unequal social system gets very often treated as just a law and order problem, leading to further violence of the state. The peaceful façade of an unequal caste relationship is achieved by the coercive power of the upper caste elite in various local situations and by fact that the state machinery is by and large not recognized.

In relating the health concerns to caste violence, one needs to point out that the two major strands of thought on redemption from caste inequalities which formed part of the freedom movement viz. the Gandhian and the Ambedkarite, did not have the health rights of the *Dalit*s as a major concern. They were at the same time concerned with various other social, economic and political rights of *Dalit*s, which were perceived as more important concerns of the period. Thus, in the social sector the thrust of postcolonial policy on *Dalit*s has been on education and employment in Govt. sector which were seen as sources of upward mobility. Together with this was the concern and efforts towards removal of untouchability. Sensitivity in the health sector turned to Scheduled Tribes, in whose case due to their concentrated habitats, it was geographically feasible to address the issue of access, though rather too formally – by fixing lower population norms for setting up PHCs & SCs in tribal areas (Basu S. K., 1990). Needless to add that the functioning of these PHCs and SCs leave much to be desired than even their counterparts in the plains. It is by sensitising the Govt. health sector itself to the issues arising from caste, that a sensibility to caste violence can also be built in. This sensitisation is one of the issues involved in developing a perspective on caste violence and health concerns. A few examples from the history of early 20th century Kerala would illustrate this further

When it was thought of officially in 1890 to start a ward for *Dalit* patients in the general hospital of Thiruvnanthapuram, the durbar physician objected to it on the grounds that it would keep away the Brahmins. (Kabir & Krishnan 1992). However it was agreed to in 1894 to build a few cadjan sheads to accommodate *Dalit* patients who did not have any shelter from the rains. Yet, the situation did not improve considerably (Ibid) until further petitioning and under the influence of the later *Dalit* struggles for travel on public roads and access to public places (George A 1990). It was only in 1905 that an unused kitchen far off from the main wards was converted in the Women and Children Hospital for the use of *Dalit* women and their children (Kabeer & Krishnan op.cit). It was again pointed out in 1911 by P. Govinda Pillai a reformist Nair who incidentally was the first *Dalit* representative in the Travancore Assembly that in the hospitals, *Dalit* patients were attended to only after the other patients and that medicines were just thrown to them from a distance (Chentarassery 1979).

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Though not in the same form and degree as in early 20th century Kerala, caste discrimination in various forms is likely to be present even today in the provision for and delivery of health care in other states as well. Th historical specialities of the regions and states will have a bearing on the nature of these discriminations, which in turn influence the response to caste violence. In this connection it will be relevant to look into the nature of caste violence, the factors involved in it and its manifestations through a case study. The case presented here is that of the *Dalit*s of the south &central Travancore region of Kerala, from the second half of 19th century to1940s. The first part as a caste movement of *Dalit*s and the latter part as an agricultural workers movement in which *Dalit*s took part. Before going into this specific case study a brief note on the social history of *Dalit*s is required.

Socio-historical background

Romila Thapar observes that though the Varna system in ancient India did not function exactly as a superimposed hierarchical layer of social groups, the identity of the untouchable remained generally clear in the historical sources of that period (Thapar R 1984). On the status of low castes during the Moghul period Irfan Habib remarked "Members of the low castes, assigned to the most menial and contemptible occupations could never aspire to the status of peasants, holding or cultivating the land on their own. It would not indeed be surprising if the actual status of many of them was semi-servile involving a kind of bondage to a particular community of caste peasants or zamindars (Habib I 1963).

Dharma Kumar noted that one of the most striking important peculiarities of the Indian forms of servitude was their close connection with the caste system. In general the serfs and slaves belonged to the lowest castes (Kumar 1965). It is the situation that is reflected, when Francis Buchnan who toured Malabar in 1807 wrote that by far the greater part of the labour was performed by slaves or Churmar (Buchanan F 1807). Churmar being a corrupted form of Cherumar, which was the most populous agrestic, slave caste in the Malbar region of Kerala. Kumar was also of the opinion that the lowest castes were probably prevented from owning and leasing land by powerful social sanctions (Kumar op. cit). That this practice was followed in Kerala is clear when we find that the Malayala Manorama (MM) newspaper was arguing through its columns in 1909 that land should be leased out to Pulayas (MM 1909) the largest *Dalit* caste of the state. Though slavery was abolished in the Malabar region of the state in 1843 along with British India (Logan W. 1981) and later in 1855 in Travancore & Cochin areas (Saradamani K. 1980) a veiled form of slavery persisted in the name of attached labour (George A. 1987). The slavery abolition laws and proclamations were not backed by any measures to provide economic sustenance to the freed slaves thus forcing them to continue as attached labour under the same owners. (Logan W, Saradamani op. cit). However the practice of slavery did ease to some extent and sale and transfer of slaves which was a characteristic feature of slavery seems to have stopped. An indication of this was the emergence of the system of attached labour after slavery abolition. (George A 1987 op. cit)

Disabilities of *dalits*

Not only that the *Dalit*s of Kerala were slaves and later labourers, they suffered from a number of disabilities and infringements of basic civic rights. The slave castes were denied admission to markets and had to stand at a distance to make their purchases and sales. They were prohibited from wearing gold and silver ornaments and allowed to wear only brass and lead jewellery (Mateer Samuel 1883). *Dalit*s were not allowed to wear anything above their waists, which strictly applied to females also. They could use chappals or umbrellas also (Jose N.K.

1982). Till they won their right to walk on public roads through various struggles, from 1890s to the early decades of this century , they were not allowed to walk or travel even on public roads , courts and other public places. *Dalit*s were not supposed to be seen anywhere near temple, educational institutions and public wells (Mateer S op. cit). Namboothiri, Nair and Syrian Christian landlords were addressed by *Dalit*s as Thampuran. On the other hand derogatory expressions such as "Eta" & "Nee" were used by the high castes in addressing *Dalit*s (Chentarassery 1979, Alexander K.C. 1968). *Dalit*s were not even allowed to use the first person singular "I" for ego references. While talking to upper castes they had to cover their mouth with their hand and refer to themselves as Adiyan is slave (Chentarassery 1979).

The rules of distance pollution prevented the *Dalit*s from taking up any employment, which put them in direct intercourse with the upper castes. This had forced them to take up wet land agriculture which was particularly unhealthy and hard labour compared to dry land cultivation (George A .1987) the nearness of drylands to the houses of upper castes prevented them from working in them (Unni R. K. 1975). In places where drylands were few there arose another kind of division of labour wherein the hardest and dirtiest tasks were assigned to the *Dalit*s. Other labouring castes did relatively less hard and dirty tasks (George A. 1987). This was particularly so in the Punja form of rice cultivation practiced in Kuttanad. the punja fields lay below the sea level and water from the side by rivers were diverted into them after each season of cultivation. Till the beginning of this century when the first mechanised pumps were used (MM 1901), this water had to be drained out before the next season by using manually rotated water wheels. The ring bunds protecting the fields from the river and lake around them, also had to be replenished using clay dug up from the riverbeds.

Gathering clay from the rivers, which required spending long hours in cold water and rotating the water wheel which again was a very heavy work, were done by the *Dalit*s who were attached labourers. Other routine agricultural tasks such as ploughing, sprinkling limestone, hedging, sowing, manuring, transplanting and weeding were done by the casual labourers belonging mainly to Ezhavas, a backward caste. *Dalit*s took part in these tasks as well in addition to other areas (George A. 1987).

Violence and resistance

In addition to mere cultural conditioning of the *Dalit*s various violent means were also used by the upper castes. The awakening among the *Dalit*s not only challenged these violent means but the caste system which legistimised it as well. The means used in this challenge were sometimes violent. In this section we deal with some specific instances of this nature pertaining to Travancore from 1850s to 1940s. Samuel Mateer an L.M.S. missionary who worked in Travancore mentioned in 1883 long after the slavery proclamation of 1855 that the *Dalit*s were subjected to very severe forms of punishments by their masters. For petty crimes they were cruelly confined to stocks or cages and beaten up. They were tied up and flogged for not attending to work in the early hours of the morning. Cases were known where *Dalit*s were blinded by pouring lime into their eyes. In another case, the teeth of one person were extracted by his master for eating his sugarcane (Mateer op. cit. 1883).

In mid nineteenth century when slavery was still in force the slave owners had the right to flog the *Dalit*s who were slaves, tie them up, mutilate them or even kill them (Chentarassery 1979). One horrible way of killing them was by tying them up to a post and driving a sharpened stick from the anus to the throat. The victim died a slow death in 2-3 days out of bleeding and destruction of various organs of the body (Chentarassery, 1979). Murder of *Dalit*s by the powerful landlords of the Kuttanad region and throwing their bodies in the several rivers and

lakes of the area is a part of the oral tradition of Kuttanad (Shivshankarappilai T. 1985). The bodies of victims were tied to heavy stones or other weights to make sure that they sunk in the waters and never surfaced. Another form of murder of *Dalit*s widely known, was done as part of a belief that their blood and bodies gave strength to protect the ring bunds around the Kuttanad paddy fields from the river and lake water around them. When there was major breach in the bund, while replenishing it, a *Dalit* was also trapped to death by a group of workers under the leadership of landlord and buried in to the bund (Kamalasanan N. 1993). This belief that human blood and body strengthened constructions of bridges and even big buildings is part of the oral traditions elsewhere in South India also.

The violence of caste was sometimes met with violence by *Dalit*s when they asserted their civic rights. In 1898 a Padayathra was organised by *Dalit*s from Venganoor to Aralumoodu market to win their right to travel on public roads. The upper castes blocked this padyathra midway. The *Dalit*s resisted which led to a confrontation in which both the groups sustained injuries. This incident inspired *Dalit*s in other parts of Southern Travancore also to clamour for the right of travel on public roads (Chentarassery 1979, Gladstone 1984, Saradamoni 1980). In another similar incident *Dalit*s tried to establish their right to travel on public roads, by presenting themselves in front of the King, when he made a public appearance for the Pujayetuppu (Dasara) festival. *Dalit*s went in a procession carrying a portrait of the King as a shield. However they were attacked on their way back. Therefore they had to change their route and reach their places by the sea, travelling in fishing crafts (Centarassery 1979) A marriage procession of the *Dalit* Christians of Agateeshwaram Taluq of South Travancore was attacked by the Vellalas in 1909 (a caste of equal status to the Nairs in that area) when it passed through a road in their street. Analysis of this case, which is profusely documented in the Judicial Department Documents of Travancore (JDDT), showed that barring stray cases of violence by individual officers. The judiciary and the police did not consider the right of travel of *Dalit*s as a natural civic right, but only as a recently granted concession from the upper castes on which the so called Hindu Shasthras still had a say (JDDT 1909, George A 1990). The *Dalit*s right to walk through the road in the Vellala locality and even to go in carts, which was regarded as an exercise of prestige, was upheld in a case in 1887 and agreed to by the Vellalas. The question was regarding their passage in a procession, which the Vellalas objected to (JDDT 1909). A procession is not just an amalgam of people like a crowd. It is an organised crowd brought together by a common purpose. The purpose in this case being an open and organised assertion of their right to travel, even though a Vellala street in the celebrant mode of a marriage procession. It is this which wounded the Vellala prestige and precisely the same which the *Dalit*s wanted to assert (George A 1990). The view of the Judiciary also coincided with that of the Vellalas. The District First Class Magistrate of Padmanabhapuram observed: "The people belonging to a particular caste or sect had, in their anxiety to maintain their exclusiveness, put up shelters and congregated together and established places of worship in the streets, occupied exclusively or for most part, by members of their own community. The roads in such streets, though maintained at public expense were not allowed to be used for purposes distasteful to the occupants of the streets" (DDT 1909). The magistrate observed: "This was the received notion on the subject" which he said was also according to the Hindu Shasthras. He said "This is a Hindu State and in the absence of statutory laws... the rules and principles in the Casters should guide the courts" (Ibid). The Police view was also the same: That the Dallies should have not passed through the Villa street as their village pagodas and temples were also standing in between (Ibid). In both these views an attempt to camouflage an essentially caste-class issue into a communal one is evident, since the *Dalit*s in this case had converted to Christianity (George A 1990).

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The right of admission of *Dalit* to all government run schools was officially granted by the Travancore state in 1910, (EDDT 1910, George A 1990) but it was not allowed by the upper castes till various struggles of *Dalit*s in this regard. The Pulaya – Nair clashes which took place in 1914 started off when Pulaya children denied admission by the local upper castes in a school in Uroottambalam, in Neyyattinkara Taluq of the South Travancore (EDDT1910, George A 1990). Pulayas are the largest *Dalit* castes in Kerala. In 1914 the Nairs of Neyyattinkara taluq petitioned to the king of Travancore that over a thousand Pulayas armed with guns, spears, axes, choppers, knives and such other lethal weapons, attached two persons travelling on the road and were creating trouble in other parts of the Taluq. The petition further argued that the Pulayas had gathered the courage to do so only because their children were also allowed to study with the Nair children in the government run schools, by the declaration to this effect in 1910 (JDDT 1914). The Pulayas however had a different story to say. In one of their petitions they pointed out that they had sent several petitions and complaints to officers of high authority about the riot that took place among Nairs and Pulayas in Neyyattinkara taluq, which included robbery and destruction of Pulayas houses and infliction of criminal injuries on them. They said that not a single police officer of the area had made an on the spot enquiry or arrested any of the accused (Ibid). Another petition of the Pulayas rather starkly stated that there was a rumour that the riot was carried on with the permission of the government and that there were instructions that grievances of Pulayas need not be considered for 3 months (Ibid). The acts of violence against Pulayas included infliction of serious injuries to them, ill-treating their women including raping them, large scale destruction of their huts, robbing their meagre gold and silver ornaments, stealing their goats and poultry and destroying their clothes – particularly decorative clothing (Ibid).

The social content of these acts of violence need to be looked into more closely. Most of these acts have a dual meaning. One, what appears at he outset, and the other a deeper socio-historical implication. Nairs in this case were trying to reestablish some of their prestige and authority over the Pulayas and push them back by one stage in history. Thus they tried to reestablish the authority of the upper castes over the bodies of *Dalit* women by raping them. By destroying the *Dalit* huts they were virtually exercising their right over the land on which the *Dalit*s had put up their hutments. By robbing gold and silver ornaments of *Dalit*s they are threatening *Dalit*s to go back to the past when they were permitted to wear only brass or lead. The same applies to the Nair ire towards the clothes of *Dalit*s, particularly decorative clothing. They were previously not supposed to wear anything above their waist and wear only soiled clothes. The robbing of poultry and goats were probably the reassertion of the old slaveholders rights, where slaves were not supposed to own anything or make an income out of it. In fact this right partially continued even over the property and produce of the small hutments on which *Dalit*s attached labourers lived.

The civic freedoms of the *Dalit*s of Kuttanad were won as a result of their struggles – sometimes violent – against the attached labour system (George A 1987). Through using fraudulent means of accounting work, the social disabilities of castes and by physical violence, the upper castes farmers of Kuttanad, saw to it that the *Dalit*s of Kuttanad were available to them as a cheap reserve labour force to do the hard and dirty tasks that were characteristic of Punja cultivation (Ibid 1987). It was the casual labourers belonging to the backward Ezhava caste who first organised with the help of the coir factory working class of Alappuzha of 1940. In 1941 this organised movement took the name of the Thiruvithamkoor Karshaka Thozhilali Union (TKTU), which was part of a configuration of trade unions in the industrial and agrarian fronts of Alappuzha district (Ibid 1987) farm labourers of the region for higher wages for transplantation. This strike which covered various parts of in Alappuzha, Kottayam and Pathanamthitta districts was taken serious note of by the Travancore administration and also

attracted the attention of new papers (Deepika 1942). The Kuttanad Karshaka Sangham (K.K.S-Kuttanad Farmers Association) sent a delegation to the authorities at the Divisional Head waters at Kollam. They said that the workers who had struck work were going about in processions shouting socialist slogans and that they were also destroying standing crops. One news paper alleged that strikes and other forms of protests, common along the workers of Alappuzha town was being put into operation among the agricultural labourers also (Deepika 1942). Through the Travancore administration offered police support to the farmers, that had to concede the demand for higher wages (Ibid). A frustrated farmer beaten up the then general secretary of the TKTU, when he approached him to stake the right to work on behalf of some pro- union workers. The workers took revenge by beating up the farmer when he was passing in a country boat (George A 1987).

It was in 1943 as a result of special efforts taken by a group of full time activists of the Communist Party of Travancore (CPT), who were deputed by the party to strengthen the agricultural workers movement (Das DJ 1983), that the *Dalit* attached labourers also got organised. Till then they suffered from a self negating sense of loyalty to their masters. They would even die for the masters. Some of the *Dalit*s themselves were used by the farmers to terrorise the CPT activists who tried to unionise the *Dalit*s (George a 1987). It was only after these activists could conduct a successful strike of a group of *Dalit* labourers in Kavalam the citadel of large farmers of the area that the rest of the *Dalit*s could believe what they could achieve. The demands of this strike which were conceded by the farmers included the correct settlement of the work accounts of the *Dalit*s attached labourers and an increase in their annual payments from the farmers. Subsequent to this strike attached labour came to be seen as a costly system of labour by the farmers. They began to cut down the number of attached labourers and eventually gave up the practice of keeping attached labour (George A 1987). Though during this strike several *Dalit*s were attacked and evicted from their home steads owned by the farmers, after the success of the strike, the *Dalit*s started asserting the various civic freedoms denied to them and casting off the shackles of caste based disabilities on them.

Caste violence and health concerns

1. Generation of Literature Dealing with Forms and Content of Caste Violence:
The above case study of 19th to mid 20th century Kerala gave us the facility to look closely at caste violence using even the Government documents in that regard. Though this facility may not be available in the case of contemporary caste violence, more studies are required on this topic. Other informative sources such as news paper reports and oral sources could be looked into with sufficient cross checking amongst them. Such studies in various regions of the country should bring out the different forms of caste violence, the symbolisms in it and the social content of the violence. This will be useful for developing a health perspective on caste violence as well as for a better understanding of caste violence. This paper is an attempt towards that.

2. ***Sensitisation of Health Sector and Health Professionals to Caste Issues in General and Caste Violence in Particular:***
In the place of a supposed modernist attempt to ignore caste, in spite of its presence in day to day life, caste needs to be accepted as a reality of Indian life which gets into village settlement patterns to marriage. Health professionals alone need not be blamed for not having this perspective for they are not the only profession of that sort. That the various arms of administration and social institutions were also not much different comes out from this case study. Without questioning our basic cultural conditioning and the class issues involved in caste, we will be going in to a "high living and low thinking" (Das A) by deceptively trying to

play in situations of caste violence the need to sensitise the profession does remain. A sensitivity to *Dalit* issues in health planning would set the right background for this sensitisation in the health sector. This involves at its core, ensuring that *Dalit* and non *Dalit* patients get the same kind of attention and treatment in the Government health institutions to start with. Given the class basis of this issue it would not be an easy task to achieve. The various quality of care studies under way in different institutions should also address the question of quality of services available to *Dalit*s.

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Paper: 3

Psychotherapy, reiki, counselling, etc. as therapeutic tools Report on cases registered in the Hope Clinic

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The national health policy 1982 of the country emphasises on the need for a shift from hospital care to Community Care. This is a step to achieve the goal of health for all by 2000 AD. Health is defined by WHO as "a state of Physical, mental, social, spiritual well-being and not merely the absence of a disease or infirmity." But this definition has been confined to the book only. And so there is a need to encourage the application of knowledge about mental health and hygiene in general health and in social Development. Keeping this view in mind couple of years back I have started a Hope Clinic, which works at the grass root level in the community. This grass root level is nothing but the stress, which you, everyone and me have to face or undergo. Most of them try to avoid this stress and as a result their life becomes more stressful. This is because they are unaware of the fact that stress can not be avoided and it has to be managed in a desirable way.

Several systematic surveys carried out in India proved that emotional problems are widely prevalent in the Urban and rural areas and affects both the rich and the poor. Physicians often fail to recognise the emotional nature of problems and patients are subject to unnecessary investigation. The most common treatments include Vitamins and tonics. This treatment fails to work on emotional level. Same things may happen with the case of surgical care, poor mental health results into delayed recovery of wound etc. Mental and bodily functions are closely related. Keeping this view today, I would like to discuss my submission about the theories which I found extremely useful while treating client who knocked the door of my clinic which is located in industrial belt at Pune. Near about 50 different cases handled with different theories in combination.

Cases like Backache, frustration, arthiritis, depression, M.D.P., Schizophrenia (paranoid), epilepsy, hysteria, spondiolysis, dementia, stress etc.

All above cases, of all together different angles challenging differently the human style of life are depending on following theories and philosophy: - Genetic, Biological, Psychological, Behavioural & cognitive, Psycho-social Development, Psycho-sexual Development and personality theories.

Mainly in last few decades a number of theories have been elaborated which aim to explain psychiatric disorders on a scientific basis. Most of the psychiatric disorders have multiple causes. The role of genetic factors is important for aetiology of schizophrenia, mood disorders, sociopath, and Alzheimer's diseases. Genetic factor also influences the development of personality. Biochemical evidence suggests that, dopamine excess of 5 HT and norepinephrine results in mania. Whereas deficiency of 5-HT and norepinephrine results in depression, recent evidence suggests that all neuro transmitters are somehow interrelated.

Here one more known philosophy, I would like to emphasise which is inspired by Andrew Carnegie. He disclosed his formula of personal achievement to the author Napoleon Hill, many years ago. Carnegie not only made himself a multi-millionaire but he made millionaires of more than a score of men to whom he taught his secret.

The subconscious mind is 90% and it is the giant mind, it receives and files sense impressions or thoughts, regardless of their nature. You may voluntarily plant in your subconscious mind any plan, thought or purpose which you desire to translate into it physical or monetary equivalent. The sub conscious acts first on the dominating desires which have been mixed with emotional feeling, such as faith, which make your positive emotions work for you.

The Mystery of sex "transmutation" has best philosophical value to gain success and keep healthy. "Transmute" means the changing or transferring of one element or form of energy, into another the desire for sexual expression is in born and natural. The desire cannot and should not be submerged or eliminated. But it should be given an outlet through forms of expression, which enrich the body, mind and spirit of man. If not given this form of outlet, through "transmutation" it will seek outlet through purely physical channels.

The transmutation of sex energy calls for the exercise of will power to be sure but the reward is worth the effort. The human mind responds to ten stimuli through which it may be "keyed up" to high rates of vibration known as enthusiasm, creative imagination intense desire, etc.

The desire for sex expression, love, music, a burning desire for fame, or power or financial gain, money. Friendship between either those of the same sex or those of the opposite sex. A mastermind alliance based upon the harmony of two or more people who ally themselves for spiritual or temporal advancement. Mutual suffering, such as that experienced by people who are persecuted. Auto suggestion fear, narcotic and alcohols.

Here I am quoting some names of great persons and followers of this philosophy. George Washington, Napoleon Bonaparte, William Shakespeare, Abraham Lincoln, Andrew Jackson and so on.

Reiki – Rei – Universal, Ki – Life force or energy.
It is one of the highest forms of energy in existence. Everyone is born with Reiki, for it is the energy of life itself. Dr. Mikio Usui from Japan had re-discovered this natural system of healing in the middle of 19th Century.

Reiki is path of self-realisation, inner-development and holistic healing.

It is interesting to note that initiation is imparted through an authorised teacher at least on the higher levels of competence for these methods. Mantras and symbols also played an important role, in this process as tools. 'Reiki' energy stimulates the body to heal. It helps to free blocked emotional energies, such as those, which have built up in two forms of armour of muscle, once again making them available to the individual. Reiki helps by triggering and intensive process of purification that which it is supported by healthy nutrition can initiate deep-reaching organic processes of rejuvenation.

Scientific information: Reiki
Beth Grey – A Reiki Grand Master has discovered with the use of very fine measuring device in co-operation with the Stanford University in California that the Reiki energy actually enters the body of the respective healer through the crown chakra. Once awakened, it flows out of the

hands of the Reiki channel and continues counter clockwise in the shape of a spiral. This means that its form is quite similar to that of the double helix of DNS, the human genes.

In recent year, Physicians, Surgeons, Naturopaths and other therapists who work with Reiki have frequently received the opportunity of proving the Reiki works and that it's effect are in accordance with information that has been traditionally handed down. Reiki creates possibilities for people without spiritual backgrounds that make it easier for them to open up to the Reiki force and develop a personal understanding of it. The spirituality will then come on its own along with the experiences.

Perhaps there we will get some time more for extensive research project to make the many life – promoting effects of Reiki visible as well for the people who have difficulty opening up to Reiki without empirical evidence. Such as scientific research on yoga and diverse methods of meditation are being known as spiritual disciplines and accepted even academic communities.

I applied all above philosophy while handling myself and clients in day-to-day life, which gave excellent positive desirable results within short period.

Assessment
Assessment was done on the basis of subjective and objective data of the client.
Methods used as tools:

Psychotherapy: Individual, Supportive, Insight, Family

Counselling: Child, legal, financial management. Time management, education, etc.

Reiki with Music & Colour: The Therapy → Attunement, Treatment, Seminar

Yoga and meditation
Breathing Technique: Simple, Raj yoga, Silvamind control

Diet therapy: Natural, balanced and fresh food.

Above tools I used in combination, for cases like depression, isolation, frustration, temper tantrum gave good result stimulation, as well as opportunity to socialise. Some of the clients were found interested in occupational and recreational activities, such as painting, cutting papers, art, designing, music and dance when given with opportunity found enjoying themselves. I also observed that in some cases new learning skill was decreased but previous life experiences helped them to recapture the past and apply it to present. So, it can be said confidently that re-motivation is the way to communicate that there is potential for activity and growth.

Some known and diagnosed of functional and organic case started responding and improving in all respects when appropriate knowledge about drugs doses was provided to patient and the relatives about antipsychotic and vasolators and other drugs which were being treated by psychiatrist. Along with group prayer, physical exercise, Reiki therapy with light instrumental music and planned diet help to minimise symptoms like suspiciousness, hallucination, thought block, illusion, restlessness and so on. Yoga or physical exercises helped to increase physical

activities and psychomotor activities and release emotions in desirable way. Music, dance group prayer or singing also help to socialise and wash out negative feelings towards self and others increase team spirit.

Some "token economy" system also introduced through family members to bust their ego and sense of responsibility and sincerity. Some time they were allowed to make mistakes by providing emotional freedom, which help to understand their own mistake in easiest way. Stressors and alcoholic cases treated with Reiki initiation, therapy with light music with guided meditation with colour 20 to 30 sitting at least ½ an hour daily. Besides that they were handled and communicated with soft tone of voice and empathetically. Diet which is rich in vitamins. I tried to use occupation as a therapeutic tool. This gave confidence to me through their quick response increased sense of responsibility; creativity decreased physical tremors, decreased alcoholic consumption.

Children having problems of arrogance, lack of concentration, bed-wetting treated with supporting and play therapy, Reiki attainment those who are above 5 years of age. Reiki therapy especially on 3rd eye chakra and solar plexus and throat chakra to released stress, fear and increased decision ability. It helped to resolve intra-psychic conflict and to develop rhythm to activities. Cases like frozen shoulder, arthritis, backache, anxiety, migraine and tried to motivate them to use their potential or energy convert into positive thinking through Reiki attainment, treatment yoga, developing skill of auto suggestion and also insisted every now and then about planned, limited, fresh food and fruits. Nursing mothers were advised to learn and apply positive thinking and simple mediation daily 10 minutes to keep themselves stress free and face shortcomings happily in their life.

Conclusion:

Of all above theories which have been used by me while treating my client are definitely very useful in general and Reiki therapy in particular. I am therefore; definitely proud of the total methodology I use for treatment of my patient with outstanding results of Reiki with flying colours. I therefore, very sincerely feel that, if a similar practice is started by the practitioners in the society I am sure that new generation will carry outstanding personalities.

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Paper: 4

Impact of riot on children

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Introduction

The W.H.O. slogan for the year 1993 was **'Handle life with care, Prevent violence and negligence'.** So you know the importance of violence on the physical and mental health of human beings.

Bombay the Urban Prima and financial capital of India with a population of almost one crore drawn from all over the nation, was regarded as a peaceful, disciplined, well managed cosmopolitan city. Indira Gandhi was killed, Rajiv Gandhi was killed, and there were problems all over the country but Bombay was peaceful. Then suddenly in Dec. 1992 and Jan. 1993 communal riots erupted and threw the entire city into confusion. People witnessed large-scale violence unknown to this city. There were dead bodies on the road. Hospitals were full of dead bodies and injuries included stab injuries, bullet injuries etc. As if this was not enough, when Bombay was limping back to normalcy, on March 12th a barrage of bomb-blasts took place in the city resulting in house collapse, massive fires and loss of lives. It was really stressful.

Everywhere there was discussion about the riots. Most newspapers in the world today are engaged in sensational news and especially in crime news. They make crime stories as colourful as possible. During this period newspaper headlines used to be how many died and how many injured in different areas of Bombay with horrifying pictures. TV news was full of violent scenes. There are many studies on mass media and violence where they mentioned the negative effects of it. Here street violence had suddenly become more real than news clips on TV or even studio set-images of burning scenes from movies. Under such circumstances social support can be viewed as a coping resource. But during this riot, social support was lost. Each and every person had become paranoid, suspicious about people from other communities even about those who may have been their good friends. Very few could distinguish between identifiable friends of a particular community whom they knew as being good and the other faceless bad majority of the same community. If this can happen to adults you can imagine what must have happened to children! In one college, good friends from two communities stopped talking to each other. A 7-year-old child of Anaesthetist asked her, "Why do you ventilate patients from other community?" One 10-year-old boy admitted in the Paediatric ward of a General Hospital was very much scared of bombs and he was checking pockets of anybody who used to enter the ward. As it always happens in such cases, it is the children who are the worst affected in a variety of ways ranging from immediate physical loss to emotional and mental trauma that could have long-term reactions.

Some schools tried to bring out their emotional trauma out of their systems by asking students to write essay, poems or by drawing. I will like to give some examples. One 8-year-old girl wrote, "I don't know why people hate us. Aren't we all God's children?"

One 11-year-old girl wrote in her poem:

'Blood, blood all around
Blood, blood on the ground
Bang, bang and a cry
Blood, blood I don't know why?'

After reading and listening to this our department decided to study 'Impact of riots or violence on children's mental health'.

Materials and Method

Our school mental health clinic visits were going on in nearby municipal school. First we decided to use CAT cards. But we were disappointed because were writing same stereotyped stories and we could not pinpoint their anxiety related to riot. So we designed a special questionnaire where some questions measuring anxiety and fear were intermingled with specific questions related to riots. We decided to administer these to 3rd and 4th std students of two municipal schools Agripada and Arya-nagar (Tulsiwadi) which were riot affected areas and are near Nair Hospital. Each question had 3 components. A 'no' response was scored as zero. If the response was 'yes to some extent' it was given a score of one and to a large extent was given a score of two.

Psychiatry residents, social worker and psychologist from our department administered this questionnaire individually. We started these interviews in Feb. 1993 but it went on till March end and those who were interviewed after bomb-blast could not differentiate between riot and bomb-blast. Total 515 students were interviewed but analysis is done in 495 cases.

Results and discussions

Age of the study group was ranging from 7 years to 12 years. There were 51.51% males and 48.49% females. There was no significant difference in total score as far as sex is concerned.

As far as religion is concerned 54.74% were Hindus, 8.89% Muslims, 0.4% Christians, 15.15% were Buddhists but 20.80% in the 'don't know' category. I really don't know whether it's a good sign and whether parents, teachers should encourage such things rather than building watertight compartments of religion. This will help to maintain country's unity and integrity. Sleep was disturbed with many of them and dreams and nightmares were present in 62.62% of students, which was significant. Contents of the dreams were frightening and they re-visualised the scenes seen in the neighbourhood during daytime. Re-experiencing the traumatic event by nightmares, is one of the essential feature in post-traumatic stress disorder. According to Paul Vaz director at Seva Niketan healing is going to be very much more difficult than normal when children have persistent nightmares. This is because pursuers in the dreams have identifiable faces, are communal and have other qualities that are very much real to the children even during their waking hours. The enemy is hardly an ill-defined phantom.

Physical symptoms like head-ache, stomach-ache was present in 40.21% of cases. Headache was predominant which was present in 21% of cases in Auster's study in 1972.

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Anxiety symptoms like feeling scared, worrying, tense, tired, nervous, breathlessness were present in 33.53% of cases which was very high as compared to Lal and Sethi's study where they found anxiety symptoms in only 11% cases below the age of 12 years which is our study population. The symptoms shown in the above two tables were associative features to diagnose P.T.S.D. The exposure to violence fosters fear out of proportion to fact, which was proved in our study:

Fear of destruction of house and property like burning, looting was present in 60.80% of cases.

Fear of injury, illness or death of self or family member was present in 42.82% of students.

Fear of going out on street was present in 39.39% of students. Fear has even prevented children from attending schools. During that period there were many reports in the newspaper. For example, one girl reported in a class of 70. Third and fourth standard were combined in one school still the total number did not exceed seven. Students were scared to go to school alone so either they used to go in a group or they used to insist that adults should accompany them. Nobody used to loiter around the school or on the way back to home which students normally like to do.

Fear of playing with other community children was present in 64.24% of students. As mentioned earlier children are unable to differentiate between good and bad so they were scared of the whole community or it may be just imitating behaviour of their parents.

Regarding total score, 11.72% had score above 10 and 9.89% had zero score. There were 76 victims whose houses were burnt or looted, family member was dead, injured or taken to jail. If we compare the score of victims to total study population it was very high. For example, in victims, 23.69% had score above 10 as compared to 11.72% in total study population. This was expected because the child who suffered directly is going to have more insecurity, more anxiety than others do. Here, there is an interesting finding: some of the victims had zero score or low score, which can be explained on the basis of psychic numbing or emotional anaesthesia. Numbing of responsiveness to or involvement with the external world by marked constriction of emotional responsiveness is one of the essential features in diagnosing P.T.S.D. Other reason for this zero score may be their denial to accept the facts or children were discouraged to talk about the riot by parents and teachers. 10% students were evacuated from their houses and 13% of them had high score.

There was strong denial in accepting the reality by teachers and principals. They were reluctant to discuss anything related to this sensitive issue. When we approached the school, their instantaneous reply was 'there is no problem with our children'. If they think their students are not aware of reality or that the riots have not really registered in their minds, they are mistaken. This is proved by our study. If teachers don't discuss with students, if parents don't discuss with their children, they will remain with host of unanswered questions.

When we asked their feeling at the time of riots, more than 90% said they were scared which was normally accepted reaction. But 8–10 of them said they were happy. This finding was unexpected and shocking. How can anybody be happy in these circumstances? We do not know whether they will turn out to be psychopaths in future. Because children affected by riot could quite well nurture hatred for each other at this tender age. The feeling could become too deeply entrenched if not dealt with at an early age. As we know, aggression is encouraged by watching other people behave aggressively.

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Three or four boys were drawn into some sort of participation in the violence and it is proved by studies that frustrated individuals who watch aggressive films or who participate in aggressive play usually become more aggressive. Even if violent scenes are repeated frequently, the tolerance of aggression is bound to be stimulated and may give rise to crime or delinquency. A survey by ABC T.V. in United States found that 22 out of 100 confessed juvenile offenders had copied criminal techniques seen in television but here it was reality.

After asking the chance of recurrence of riot, 52.32% said it's definitely going to recur and whatever days they predicted were related to some religious festivals. On probing in detail, they were unable to give any explanation. May be like a parrot they were repeating the things they had heard in their homes or around. 29.49% felt there wouldn't be any more riots. At least few had a positive thinking. 18.18% were not included in any group because either they did not reply or their reply was 'can't say'.

The idea was to screen and identify students who are badly affected because detection was not easy as teachers were unable to read the signs or may be everybody accepted this behaviour as normal at that time. The common behaviour pattern following a catastrophic event has been called the disaster syndrome. This may not happen immediately after trauma but instead may be brought on by some minor stress several weeks or even months later. That's why we decided to do the follow-up of the students who were either victims or where score was more than 10.

Follow-up was done with the help of same questionnaire. There were 104 such students but we could interview only 59. This was because 12 students had dropped out of the school, 20 were chronically absent and we did not know whether they were continuing or dropped out, 13 had left school after passing 4th std. All of you must have read the statement of the Education Officer of B.M.C. in the newspaper where he mentions 30,000 dropouts in Municipal Schools that year. In municipal schools dropout is not a rare occasion, but such large-scale dropout is really something to worry about.

We tried to compare the score of 59 students in March and July. We found that the score has definitely come down from 57.62% to 11.88%, which means impact is reduced. (But if we take the total study population, score above 10 has remained exactly the same, that is 11.88% in place of 11.72%, so the problem still persists).

But fear of destruction of property, fear of harm to self or family member still persists and dreams and nightmares in majority of them. When they were speaking about the riots they could convey the anxiety. The students knew everything about the riot, they knew questions are repeated but the answers were different.

Conclusions

Psychiatric morbidity was high in the total study population.

Score was high on riot related questions in the beginning as well as in follow up study.

Victims had very high score followed by students who witnessed the violence, followed by students who only heard about the riot because they were not exposed directly or had minimal exposure because they were shifted to other safer places.

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The scale of score also reflects the degree and type of violence witnessed. For example, firing, stabbing taxies burning, houses burning, throwing stones, soda water bottles, or fireballs. That's why there was significant difference in total score in two schools.

The score varied with type of accommodation: children staying in hutments had more insecurity and high score than children staying in chawl system.

Outcome

Time is going to decide what happens to these children in future. So long term follow up is necessary. Various possible scenarios in future could be:

As the time passes they may forget the whole episode.

At the moment it may affect their studies and influence their personality.

Over-exposure to violence may change their attitude. They may realise that indulgence in such violence does not necessarily lead them anywhere so they may become passive observers and less likely to participate in the violence..

One study by Eron and Huesman has found that viewing violence at age eight predicted aggressive behaviour at age nineteen. But one recent study by Huesman et al 1983 showed that the imitative aggressive behaviour of second graders could be reversed with appropriate training and treatment, which should be the aim of mental health professionals.

There is a possibility that revenge may get nurtured in them which will mainly depend on the social environment especially attitude towards violence held by parents and elders in the society. Any stress ultimately ends in returning back to normal in a more matured way. They may have psychosomatic problems or emotional problems and so on. So mental health professionals should try to help the victims in returning back to normalcy or more matured stage than before. I don't think they require medicine but counselling was a must especially group counselling. Supportive psychotherapy, catharsis and abreaction may help them or behavioural modification with the help of relaxation. We are planning to do detailed work up of the students whose scores were high even on follow-up.

Here I will like to end with Mahatma Gandhi's words *"I hold that the more helpless the creature, the more entitled it is to protection by man from the cruelty of man".*

Tables:

Demography

Age	7 to 12 years	
Sex	Boys	51.51%
	Girls	48.49%
Religion	Hindus	54.74%
	Muslims	8.89%
	Christians	0.4%
	Buddhas	15.15%
	Not aware of religion	20.80%

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Somatic symptoms

	Number	Percentage
Present	199	40.20%
Headache	148	29.89%
Stomachache	90	18.18%

Sleep disturbances

Sleep disturbances with frightening dreams and night mares with revisualising the scenes seen in the neighbourhood or T.V present in **310 cases that is 62.62%.**

Anxiety symptoms

	Number	**Percentage**
Feeling scared, tense, worrying	166	33.53%
Fear of destruction of house	301	60.80%
Fear of injury, illness or death	212	42.82%
Fear of going out	195	39.39%
Fear of playing with other community	318	64.24%

Score

	Number	**Percentage**
Zero	49	9.89%
More than 10	104	21%
Victims	76	15.35%
More than 10 score in victims	18	23.68%

Score after 6 months

Out of 104 only 59 cases were traceable. **More than 10 score in 7 cases (11.86%)**

Paper: 5

The present day ICU-ICCU hospitals in the city of Mumbai

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Summary

The phenomenal mushrooming of Private ICU-ICCU Hospitals – Critical Care Hospital – in the city of Mumbai, India, parallels with commercialisation of medical profession and is fast devouring all the ethics and morals of the profession. They are in fact '**Death Traps**', and do far more harm to unsuspecting critically ill patients. There are no standards even minimum in setting up of critical care units, which form part of private nursing homes, which are all unregulated, unchecked and cater to almost 85% of population of Mumbai. The aim of this study was to evaluate the data collected on basis of questionnaire and on site visits. The analysis is projected in "**Realities"** as they exist in the name of so called '**Critical Care**'. The glaring deficiencies found in each and every unit in various aspects are presented. The infrastructure, equipment, services offered, human power, monitoring facilities, emergency care, procedures available, qualification of specialists, qualification of duty doctors & nurses, protocol of critical care if any and other basics to call them critical care units are studied, analysed and presented.

The only uniformity to label them as "Critical Care Hospitals" was the Big Neon Light Hoarding, 50 to 70 square foot space for bed and gadgets, ECG Machine, Cardiac Monitor, defibrillator, Suction Machine, Oxygen Cylinder, Ambu Bag with tubes, some injections, besides the presence of Non-Allopathic -(Homeopath & Ayurved) doctors on duty and unqualified nurses and absence of qualified specialist in the premises. The acceptance of 'Death' as 'Destiny' by philosophical Indians, coupled with impossible, prolonged redressal system, total lack of support to public from any quarter and defunct medical council, allow these units to function and survive unchallenged. Apathy on the part of the Government, Municipal Corporation, scores of medical associations including that of Indian Society of Critical Care has been responsible for this situation.

Introduction

"Unless I made(sic) a stand and did something about the plight of 'Critical ill patients' admitted in private ICU-ICCU hospitals in Mumbai (Dr. Orrs' Detainee) I would be compromising my moral beliefs and perception of my professional responsibility. My conscience told me that I could no longer stand by and do nothing".

The pathetic plight of this vulnerable class deceived in the name of critical care, provided compulsive force to study, analyse and present the results and put for the data to project as to how the most fundamental human rights, 'The Right to Life' is totally violated by these hospitals.

The medical nursing homes in Mumbai have tendency to put even one bed as 'Critical Care Bed' for every 6 to 8 general care beds and proclaim to be ICU-ICCU hospital.

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The specific objectives of the study are:

To study the infrastructure, equipment, staffing and overall functioning.
To examine existence and/or non- existence of regulation by various bodies expected to be responsible and the role of these bodies.
To study the feasibility of implementation or otherwise on the basis of Questionnaire prepared.

ICU-ICCU Hospitals were studied. The questionnaire was prepared on the basis of study of standard critical care books. Literature and visits to municipal hospitals and discussions with experts ethically and morally concerned and knowledgeable on the subject. The help of specialists was taken for site visits.

The data collected, analysed and presented relates to the qualification and availability of specialist in charge of ICU-ICCU, the qualification of duty doctor and nurses, type of management, infrastructure equipment, services offered, type of services and cases admitted, human power, protocol of critical care, type of monitoring, procedures available, availability of routine and emergency drugs and charges levied for such care as also the cut and commissions.

The critical analysis in detail is pertaining to 40 private ICU-ICCU units run as single or partnership ventures usually by doctors of varied specialities and at times by businessmen, with the help of specialists on call. Although 40 ICU-ICCU hospitals were studied, the scenario was similar in all of them and if all such units all over Mumbai and suburbs were studied, the outcome of study will be the same.

Tools and Methods

In Mumbai, four categories of ICU-ICCU Hospitals function. The free Government and Municipal Public Sector hospitals, the highly subsidised - Charitable Trust Hospitals, Private Trust and Corporate Hospital with most modern super speciality wings with facilities for ideal critical care but prohibitively costly. And the fourth category is that of the totally private single or partnership ventures usually run by doctors belonging to varied qualification and at times by businessmen with doctors on call and charge heavily for poor services.

This is the study of 40 private ICU-ICCU hospitals, randomly selected and belonging to the last category. These hospitals admit cases for critical care referred by family physicians, specialist practising in the area, owner doctors admitting their cases and at times patients directly come for emergency admissions. The doctor on duty who is a non-allopath examines the admitted case. The specialist may or may not come to visit and orders treatment telephonically to the non-allopath duty doctor. The specialists visit their admitted cases once or twice daily but the round the clock critical care, monitoring, critical care assessment, progress and deterioration is left to the Non-Allopathic duty doctors and unqualified nurses. The in-charge and specialist being the only qualified doctor is not always available in premises and in emergency situation that proves hazardous.

The various specialists are attached to various other private ICU-ICCU hospitals or to Charitable, Municipal and Government Hospitals. Obviously any emergency likely to develop in the set up of critical care at any time of the day or night will result in certain deaths. There is no special knowledge or training in critical care medicine amongst the specialist owning and managing the units. The branch of speciality in which they practice is the only knowledge of that branch acquired during training. They have no real knowledge of other systems of the body

and the likely associated system failure that may come up during the course of illness in critical care.

Except the specialist attached to the teaching hospital, the medical knowledge of recent advances is meagre. These specialists running from hospital to hospital have neither the time nor the aptitude. There is no compulsion for continued medical education in our country. The critical care needs holistic approach, and in the absence of exposure to recent advances and the narrow-minded approach of presenting symptoms of one's speciality only, result in misdiagnosis, resulting in wrong treatment and even death. Often the cases are admitted as ICU-ICCU cases without the need, simply because the bed was vacant. The fear created in the mind of the patient due to admission, itself causes avoidable calamity. Nowhere the names and qualifications of Resident Medical Officers are displayed. These doctors are recognised by white apron and dangling stethoscope by the unsuspecting public who believe them to be allopathic doctors. The public has no way to find out or question their qualification in the absence of their name on the display board and on the apron. These RMOs are non-allopaths, namely Homeopaths or Ayurveds and not trained in allopathic medicines. They have acquired practical training by hit and miss method.

These non allopathic RMOs even start the treatment on their own. They give D.C. shocks in the event of emergency in the absence of a specialist who is never present in the premises most of the time. The specialist is subsequently informed if patient survives and visits at his convenient time. In all the 40 hospitals, the doctors on duty were either homeopaths or Ayurveds, with occasional Allopath or specialist for short duration.

The availability of qualified doctor round the clock is the most basic requirement of any critical care unit. The critical care needs to be closely watched and monitored by qualified specialist. Hence at least three specialists on 8 hours duty should be available for any unit to be called 'CRITICAL CARE UNIT'. The owner or specialist or administrator incharge violate the basic right of the critically ill admitted patient by delegating duty to Non-Allopathic doctor for 24 hours management and himself moving to various other hospitals travelling from his place for 10-20 km distance. He can never reach the ICU-ICCU hospital because of the distance. The most common indication for emergency admission is heart failure. In fact most of the ICU/ICCU hospitals were put up for prompt attention to such cases wherein distance is deterrent for prompt treatment.

The medico legal cases were refused admission in most units, but the main reason for refusal was monetary rather than the need for such admission. Average stay for ICCU care is 2-3 days and for ICU care 3 or more days medically. However, in most ICU/ICCU the criterion for stay was monetary. Even when there is no need to occupy ICU/ICCU beds the patient continued to be kept on the bed and transferred out when fresh cases arrive to occupy the bed so that the ICU bed earns all the time. The charges for ICU/ICCU care varied from area to area and in different hospitals. The minimum charges varied from Rs.600 to Rs.800 per day and maximum charges varied from Rs.1200 to Rs.1500 per day. The above charges include cot charges and use of cardiac monitor only. Extra charges are levied by hospital for use of oxygen, defibrillator, ECG, laboratory tests, medicine charges, use of respirator and other gadgets as per the need. All catheters, syringes and disposables are charged extra or replaced.

The charges of visits by specialists are variable as per the whim of the specialist and time of visit. It varies from Rs.400 to Rs.1000 per day. Each follow up visit is charged half the first visit charge for that day. The total expense per day comes to Rs.2000 to Rs.3000 minimum for average admission. With 85% deficiency in private ICU/ICCU in every aspect of services, the

charges levied are very high by Indian standards. These units had only practical trained nurses and had no formal training even in routine nursing care. They posed as knowledgeable staff but in fact had no concepts of critical care.

Both the categories of staff, nurses and non-allopathic doctors form the backbone of these units and offer round the clock services. They learn by trial and error at the cost of the life of the patients, and are mechanical in approach, devoid of critical care concept. The salary paid to nurses and RMO is around Rs.1500 to Rs.2000 per month. Thus, the saving on salary is substantial. The salary expected by qualified nurses is around Rs.6000 to Rs.7000 and by specialist on duty around Rs.15000 to Rs.20000 per month for 8 hours duty.

It was not possible to obtain the data about mortality as no separate record is maintained cause of death for the case admitted for such care, specifying ICU/ICCU mortality. For private nursing homes of all types there is no system of medical auditing by any agency, public or private. Most of the deaths are accepted as recorded in death certificates. Public accepts death inspite of doubts due to lack of knowledge, support from activists medical or non-medical, and defunct medical council and inefficient judiciary.

The most effective outcome of ICU/ICCU admission is when done for observation and monitoring. However, this concept of admission for precautionary measures for high-risk cases, is glaringly absent not only amongst public but even amongst family physicians, specialists and even doctors running these set ups. These admissions are done for observation and monitoring and for timely diagnosis on life threatening situations, which may come up any time during the night or day. The destiny alone is the solace as obviously the unqualified staff cannot and is not expected to have the knowledge of diagnosis and treatment, and obvious outcome is death. The service of relatives is solicited for nursing care such as sponging, giving medicines, giving bed-pans, feeding, making beds. But the most deplorable aspect is the task of observation of monitor which is delegated to the relative, who has to report changes in cardiac rhythm on monitor and deterioration in condition of the patient and awaken the sleeping RMO and nurses and alert them.

All the 40 hospitals under study offered commission for referral. The percentage varied, the specialist also got commission by the owner of ICU/ICCU for referral. The specialists themselves gave commission for referral to family physician. Some family physician had to be paid deposit of Rs.1000 to Rs.25000 by the specialist and hospital. The accounts are settled subsequently as per the total monthly receipts. On an average 30 to 40% commission in eastern suburbs and 40 to 60% in western suburbs of Mumbai is the prevalent rate.

This commission heavily burdens these ICU/ICCU units and largely results in compromised substandard services at highly inflated rates for the patient. The ethics of all doctors become non-existent and tendency is to extract more and more, very often wrongly. In all 40 hospitals, equipment available to call it ICU/ICCU was mainly cardiac monitor, Defibrillator, ECG Machine, Suction Machine, Oxygen Cylinder and Ambu Bag.

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Table: 1: Analysis of equipments or gadgets

Equipment	Avail able	Not avail.	Equipment	Avail able	Not avail.
Central monitor	21	19	Holter moniter	02	38
Ventilator/ respirator	12	28	Generator*	23	17
Central oxygen	08	32	Fire extinguisher	03	37
Pacing	16	24	Image intensifier (fluroscent)	-	40
Pulse oximeter	10	30	Central suction	03	37
2-d excho-Cardiography	10	30	Arterial blood gas analyser	-	40
Infusion pump	03	37			

Only 21 units had central monitor out of 40 under study. The unit with one to three cots does not keep central monitor. The location of central monitors was in the consultant's room in 6, in ward of ICU/ICCU cubicles in 4, at reception counter of ICU/ICCU in 11 and no central monitor in 19. In the present study, out of 40 units, respirator was not available in 28 units. There was no need of respirator in ICU set up, as per the views of certain cardiologist owners. This view was most shocking.

In the event of respiratory failure, they "Intubated the case with endotracheal tube and started ventilation with Ambu Bag and transferred the patient in that moribund state to other Trust or General Hospital to be put on ventilator. One can easily anticipate the outcome of such transfer of dying patients.

The pace maker facility was available in 16 hospitals. In the absence of highly technical knowledge for it's use, wherein the specialist is needed on the premises promptly, such facility is of no use. The absence of a qualified doctor at this critical juncture is a sure death. Life saving gadgets and equipment on power, need functioning generator.

The fire extinguisher, fluorescent image intensifier and the arterial Blood Gas Analyser were not available in any of the 40 units. The equipment and gadgets being not periodically checked and serviced, the proper functioning for it's routine and emergency use was doubtful. Although oxygen cylinders were in enough number for direct or central oxygen administration, very often there was no oxygen in the cylinder and simply the catheter or mask was put symbolically. The central suction was available in 3 units. Facility and expertise to do the various procedures are mandatory requirements in each ICU/ICCU unit. The need for 24 surveillance by qualified and trained personnel can not be over emphasised.

The central venous line is used selectively and often avoided due to practical difficulty and deficiency, hence inspite of special catheters in premises it was often avoided. The most invasive procedures are avoided in the units, as it needs proper infrastructure, knowledge and qualification.

The facility of intubation by endotracheal tube was available in all units. However when need arose for intubation, they were neither available on spot, nor in correct size and number and most important aspect was the person who can perform endotracheal intubation, a life saving procedure was not always available and it was a matter of chance for survival of the patient. Intercostal drainage facility is available and done but none of the other invasive and specialised procedures such as intra-cranial pressure monitoring was possible in these units.

Table: 2

Name of the procedures	Available units	Name of the procedures	Available units
Central venous lines	4	Intercostal drainage	30
Swann ganz cathether	No	Intracranial pressure	No
Total parenteral nutrition	No	Bed side cardiac pacing	16
Invasive arterial blood pressure	No	Ventilatory support	07
Endotracheal intubation	36	Bedside bronchoscopy	No
Tracheostomy	16	Bed side dialysis	No

Fluroscopic Facility and image intensifier were not needed as per the opinion of specialists and pacing was done under Cardiac Monitor Control.

Other facilities in ICU/ICCU units

Table: 3

Items	Not available	Available
Drugs of routine use	18	22
Drugs of emergency use	25	15
Streptokinase on premises	32	08
T-pa	40	Nil
Nitroglycerine	32	08
Heparin	32	08
Laboratory in premises for routine test for special test & blood enzymes	38	02
Recuscitation equipment & drugs on trolley properly stocked & checked	38	02
Blood bank on premises	39	01

Some units are linked as collection centre for laboratory. There was no standard written down protocol or format for critical care in hospitals. Each individual had ones own whims and method and even that varied with each admission. Each specialist had ones' own plan of visit as to the time, number of visits, timing of visits and charges. The basic and specialised tests for every admissions and twice daily E.C.G. and Cardiac Monitoring are implied for every admission for ICU / ICCU treatment and management and for all admissions done for observation in such units, this is not done as a matter of routine by them. However, no uniformity of management, no common platform of discussion and teamwork existed anywhere even when more than one specialists were involved, in management of case.

In middle of night and odd hours relatives run near and far to get drugs like streptokinase, t-PA, nitro-glycerine, urokinase and often made to pay fancy prices by chemists who are also linked with these units. The facilities for cathlab for angiography and angioplasty are not available in any of these units.

Results

The discussion with Cardiologist, physicians, surgeons, anaesthetists and others who run such set up themselves or admit their cases frankly agreed that these units cannot be proclaimed as ICU / ICCU at all. There was total absence of minimum standard in general and critical care management in particular as also the absence of set protocol, absence of data recordings in proper format, in all units. Originally put up for cardiac emergency these set up are not suitable for critical care of other category of patients. Area for single cot for ICU being 50 to 70 sq.ft. Is extremely insufficient to tackle emergency management needed in critical care. Human power available is not adequate in number for number of cots laid down. It is distressing that critical care is delegated to unqualified nurses and Non-Allopathic. (Homeopathic and Ayuevedic) medical persons, projected as expert 'Doctors' to the public and thus cheating the public. There being no monitoring mechanism of regulatory authority in the country.

There is no update in knowledge of doctors. No care is taken about facilities essential for patients such as telephone, refreshment, clean drinking water, clean linen, dust proof adequate space, toilet, wash basin and place to rest for relatives. In fact dust and cobwebs were noticed. The essential equipment, drugs and services are not available which are absolutely necessary. Ventilator, pacing intubation, essential life saving drugs, laboratory for routine and specialised blood tests and blood Enzyme studies are not available in premises at the critical juncture. Visiting specialists do not attend to the cases as needed for such care, although they are aware that medical care is at the mercy of unqualified staff. The specialists totally lack holistic approach, needed in critical care and are oblivious of the fact that human being is not an assembly of organs. There is no auditing of mortality by any agency. 2D Echocardiography, Pulse Oximeter, Image Intensifier, Portable Sonography, Central Lines, Swan-Ganz Catheter, Blood Gas Analyser facilities, Tracheotomy, prompt availability of routine and emergency drugs on trolley not available in most of the set up. Total lack of checking for nosocomial infection in all units was noted.

Ambulance and heart brigade facility may or may not be available in time from outside, causing risk to the life of cases. The cut and commission existed in all of them. The minimum parameters to be monitored regularly are temperature, pulse, respiration and blood pressure and even that is not done as routine or as often as needed. Investigations needed such as blood count, X-ray, Chest, Blood Electrolytes, Blood Chemistry, Blood Sugar are often not done as routine. Detail serum Enzyme, CT-Scan, MRI Study are often postponed due to lack of holistic approach in management.

Facility for invasive procedure is not available in most hospitals. The cases needing ICU / ICCU may need the facility for various invasive procedure at any time during the illness. This is avoided as they are unavailable or delayed and often patients are transferred by ambulance in moribund condition.

Discussion

The "Saving of Life" is actually the purpose of critical care admission. However, this very purpose is not served as there is 'nothing' at all in all aspects to call and project any of these private ICU / ICCU units as 'Critical Care Units'. "India is a poor and developing country" is merely an 'alibi' to cover up all that is offered in the name of critical care. There is no justification whatsoever to offer such services to critically ill patient who wants to live and instead dies and yet charged heavily for all that poor, substandard services. Whether due to design or ignorance, commercialisation or lack of respect for human life, the setting up of

"Death Trap" in the name of private ICU / ICCU in its present form is deplorable. And be forthwith banned by one and all, be it by individual activism, medical council, various medical associations and the most effectively by learned specialists and intensivists themselves. Legal action in its present form cannot be an effective remedy, for the 'fatal disease' suffered by the public by allowing 'setting and running of 'private ICU / ICCU' One Man show' hospitals.

In fact, the data presented and analysed clearly indicates the glaringly obvious outcome depicting the miserable health care provided to the public by private ICU / ICCU Hospitals and that too at tremendous cost. Economically, it is impossible to set up and run private ICU / ICCU Hospital with 'Maximally' minimum standard. The infrastructure and equipment needed even for that low standard will cost rupees one crore at least, besides monthly expenses of at least one lakh rupees. The reading of medical journals attending medical conferences and workshops, national & international visiting and medical stalls in conferences and holding high tech discussion are all meaningless, when in reality these very medical experts themselves run above private ICU / ICCU and other specialists admit their patients in them.

For every hospital and nursing home the standard has to be laid down for that particular services in addition to general minimum standard for all and these must be made legally binding. There is also a crying need to formulate laws and regulations (non-existent at the present time) that govern the establishment and functioning of critical care units in Mumbai.

Financial lure will otherwise continue to allow the mushrooming of so called intensive care units which are veritable death traps for unwary unsuspecting patients. Our current private ICU / ICCU hospitals in Mumbai must recognise and adapt to the realities of available resources rather than permitting inadequate or inappropriate care, detrimental to the health and life of the public.

There is everything in a 'name'. When you name it ICU / ICCU hospital – CRITICAL CARE HOSPITAL – it should give that care. The very life of these unfortunates cannot and should not be allowed the be extinguished at all at any time by anyone.

"What skill is there in deceiving those who put faith in us"
"What manliness is there in killing one who is sleeping in our lap?"

CEHAT, Mumbai, India

Paper: 6

Feminist counselling and its methodology

Ila Pathak and AWAG
AWAG
Ahmedabad, India

Feminist counselling
Counselling

Counselling as commonly practised in Gujarat's Family Counselling Centres puts family at the centre of the counsellor's concerns. 'Family has to be saved' was the motto and so all efforts were directed towards that. In a dispute (i.e. a case) brought to the centre the parties were asked to arrive at a compromise. The husband was asked not to batter his wife and the wife was advised to be careful about serving him so that he was not annoyed. In the process largely the woman was asked to improve her behaviour, the husband was asked to promise that he would not torture her. Once the compromise was arrived at the parties went home, some counsellors followed up some couples for some time. Ms. Charumati Yodha, who initiated the system of rescuing tortured wives and restoring them to the family after getting promises from the in-laws, was full of remorse about the process during the last months of her life. She kept saying that the promises were not kept and the wives committed suicide soon after.

Apart from the concern for family the other important concept was that 'a case' had to come to the counselling centre to seek counsel. This could happen only when there was information among the public about their existence. Moreover only those women could approach who had the support of their natal family and were provided the means to do so. This was largely lacking so the cases brought by men were also registered. After all a man's marital problem involved a woman also!

AWAG's approach

When AWAG started running a counselling centre all this came up as a challenge with the first case registered. The women who came up asked the first question whether AWAG considered woman equal to man and if so, would AWAG ask a woman to accept battering from her husband. The answer to the first question was in the affirmative; the answer to the second was negative. The 'case' had come to AWAG as a rebound from another local counselling centre. She wanted the custody of her child whom her husband, after separation, had stealthily taken away from his school. The first counselling centre, after a number of sittings had told that the husband could keep the child and if she wanted to be with the child, she must accept occasional beatings. The woman did not agree with the 'judgement', so she came to AWAG.

Upholding the woman's dignity as equal to man within family is as important as saving a family. So in AWAG the major concern is the woman, her perception of her predicament is seen as vital to the solution of her problem. She is asked to think of alternative solutions that she could accept and then is helped to achieve what she considers best for herself. This kind of counselling is certainly woman centred. Most women want to go back to the marital family if they are treated equally (that means: they are not beaten) so the counselling process ultimately bring about compromise and saves the family. The difference lies in the treatment of the case and in the outcome. The woman is assured that she could reject the compromise as soon as she

felt that she was not treated well. Many women keep coming back for organisational assistance and support even after they go back to their marital homes.

The incidence of deaths of young women has not decreased anywhere in India. In Gujarat also this has been rising disturbingly year after year despite as many as 52 Family Counselling Centres located in Gujarat. This could be arrested only when young wives feel secure in their surroundings. In family centred counselling the emphasis is on the family so the woman does not have reassurance about herself. Her status remains subordinated. Put graphically it would look like this: M

F
Children.

When the family centred counselling process gets under way the resultant product is either the same, i.e., M

F
Children.

Or it varies: The F dies prematurely in mysterious circumstances and the Male head of the family takes another female to continue the family. This can be seen as: M M

(F-dead) F1

Children Children

Feminist counselling does not agree with this.

It hopes to establish the family as

M F
Children

This is brought about when the counselling process inspires confidence in the counselled's mind that she was right in complaining against the treatment meted out to her, that she need not survive as a persecuted being but that she could live as an individual and that she would get support from the organisation if she had trouble again.

Briefly speaking, the feminist counselling process challenges the subordinate status of the woman in her family by rousing her own individuality. Her marital family gradually accepts this, as the continued organisational support to her becomes evident to them.

In order to reach out to the poor slum-dwelling or rural women, AWAG started holding Awareness-raising workshops among them. The women, whose perception of their individuality is raised, start asking questions about being battered. They realise that they need not have suffered so. When AWAG's field workers are around they approach them and ask questions or when a field worker notices a woman in trouble, she reaches out to her. AWAG's field workers are trained in 'primary counselling' so initial help is provided by them. When a woman finally decides to take any step to get away from her predicament, she is helped by the field worker to reach out to the counselling centre of AWAG.

The method

AWAG has documented the established procedure evolved in our experience. The intervention process is divided in three parts. However, they may overlap at times.

The first meeting and the initial phase

Intake procedure requires the counsellor to take down the particulars of the counselled such as age, sex, income, caste, etc. Then the women are asked to narrate their concerns and later, to give applications specifying their expectations from the agency. This serves the dual purpose of clarifications and of focusing on the problems of the helpees as well as expectations and often writing details about self has a cathartic effect for the women.

The counselling process includes establishment of rapport and establishment of structure. The counsellor provides space to the woman helpee to express herself and builds conducive atmosphere for establishment of rapport. The counsellor establishes structure such as information about the agencies, time of the meeting and the meeting places. The counsellor also outlines the goals of the counselling and the process. She assures the helpee of confidentiality.

The goal of the helpee woman in the initial phases is to explore her experiences, behaviour and feelings relevant to the problems in her life. The woman also explains the way in which she feels she is being violated or feels helpless. The woman specifies the help that she needs from the agency. The helpee also has to work out resistance, if she has any, to external help.

The goal of counsellor is to respond to the counselled woman and listen to the content and non-verbal messages with respect and empathy. The counsellor seeks to work towards building an effective and collaborative working relationship. In order to facilitate the counselled's self-exploration the counsellor has to deal with the resistance of the counselled and be self-aware that it does not affect herself as a counsellor. The counsellor provides attention and communicates understanding.

The skills used by the counsellor are listening, questioning, (especially open-ended question) clarifying, summarising and assurance facilitating ventilation, reflecting possible feeling, etc.

Second Phase

In this phase, the counsellor helps the counselled to identify the problem and focus on it. For instance, at times, a counselled woman may be so bogged down with problems that she could be jumping from one to another. The counsellor while acknowledging her problems helps her focus on the most pressing one and helps create goals.

The counsellor's role is towards integrative understanding of the individual in her situation. The counsellor begins to piece together the data produced by the counsel in self-exploration phase. She sees and helps the other to identify behavioural patterns, to see the larger picture of reality. She teaches the counsel the skills of going about this integrative process herself. Often, the counsellor shares insight gained during the procedure in order to enhance self-awareness of the counselled. The counsellor also changes the counselled's perception of problem. Environment modification is also interlinked in the process.

For instance, a woman approached AWAG for the help to get maintenance from her husband. During the second phase of counselling, the woman admitted to herself that while she needed financial help from her husband, actually what she feared most was the marital rape.

Environment modification in this woman's case was at several levels consisting of confronting the husband and thus, raising the issue of his violent behaviour. It also included helping the

woman to get training and work towards financial independence as well as initiating legal procedure.

The goal of the counselled is dynamic self-understanding. The gradual clearing of perceptual reality makes the counselled see the need for change. The counselled learns from the counsellor the skill of putting together the larger picture herself. The counselled identifies her resources, especially unused resources.

It seems necessary to explain a fraction of the process with the field illustration. For instance, violence against women in the family is socially sanctioned and involving external agencies is seen as dishonouring the code of silence and pointing fingers at the "family honour" by the concerned family, as well as the society. Women internalise it and as a result, while talking to the counsellor, they may not mention the violence, or minimise it, acknowledge guilt, feel unrespectable, even try to justify it. The counsellor challenges these concepts of "family honour," their silence, guilt, etc. The counsellor also helps women trace the pattern of violence on the perpetrators and the silent, supportive or indifferent spectators. The counsellor helps them come out of the sense of victimhood, too. The counselled women gradually learn to identify their support systems and work towards building other support systems.

The counsellor uses skills such as reality orientation, correcting perception, guidance, suggestion, probing accreditation to the helpee, reflection of possible feelings, paraphrasing, interpretation, etc.

Third phase

In this phase, the process focuses on identification and assessment of action plan, its implementation and dealing with the consequences of these.

The counselled woman's goal is towards facilitating action and following up these actions. The counsellor collaborates with the counselled woman in working out action programme, and helps the woman to act on the new understanding of self. She also explores with her a wide variety of means for engaging in constructive behavioural change. Also, she gives support and guidance to action programme. To explain, once a woman decides that she would not let her partner violate her, the strategy of how to counter violence from her partner is thought through. The counsellor invites suggestions on possible strategies and at times, offers some. For instance, they arrive at three countering tactics, often used by AWAG counsellor. One is to say 'no' to violence, the second to hold his hand, or hit back and the third, to involve other women members of the community to pressurise the man. The counselled acts on the suggestion. The counsellor helps her in her process to confront and face consequences of the actions. Thus, by learning to respond to and control the environment, the counselled changes conflictual situation in a self-satisfying manner.

The counselled woman's goals are to learn the skills to handle the social-emotional dimension of life. She learns to change self-defeatist and self-destructive attitudes and learns to use emotions constructively. To explain, in a case when a man has deserted his partner, to be with another woman, the deserted woman often entertains the idea of revenge, makes vengeful suggestions, causes disturbance in his 'other' family etc. The counsellor works with the woman so that she is better able to accept the separation, integrate and change distressing feelings through re-education and reordered thinking about negative feelings of helplessness, powerlessness and anger and helps her channelise it in constructive activities. The counselled

woman's goal is towards developing new resource, strengthening positive bonds and nurturing other relationships.

The counsellor uses techniques such as anticipatory guidance, encouragement, accreditation to the counselled, interpretation, summarising, paraphrasing, etc.

Family intervention

While individual counselling is beneficial to women, the counselling process is not in isolation, but lined with the social environment of the counselled. The pro-woman counsellor also works towards challenging individual woman's oppression, exploitation or violation in the family, as well as in the community.

The process of counselling begins with the woman when she gives an application. If the woman wishes to involve her family members or the perpetrators of harassment or significant others, the counsellor contacts those persons. The counsellor makes home visits to access the situation, as understanding the family.

Dynamics and the social milieu of the counselled, goes a long way in effective intervention. Home visits are important tools of assessing the social environment of the counselled women. The counsellor can observe the number of people, family hierarchy, physical and emotional space that the members have within the house, family environment, division of labour between the family etc. The counsellor can understand parent–child or in cases of marital discord, the inter couple relationship, especially in a joint family. She can assess the counselled's interaction with other family members, she can pick up the dominant, weak or enmeshed relationships, identifying strong and co-operative bonds. Certain creative and practical solutions such as partition of house etc. can be worked out, based on the information.

When both the parties come together in joint meeting to discuss their concerns, to identify the problem and to work towards desired goals, the facilitative efforts remains towards reaching mutually agreeable decisions. Theoretically, the decision making process in joint meeting is as follows:

The parties determine the concern to act upon.
They project possible alternative action.
After that, they review possible consequences of action and choose the best alternative.
The parties decide on the best alternative and how and when to implement it.
Implement.
Evaluate the result, and determine whether future planning will be required.

However, many other stages also come during the process. In the first stage of the joint meetings, the counsellor paraphrases versions of both the parties and introduces key conflict areas for discussion.

The pro-woman counsellor also safeguards the woman's rights to present her case and to determine the course of action. Often during the joint meetings, the woman is silenced by her / his family. The counsellor helps the woman to overcome these pressures and encourages her to speak out. It is observed that many a times parties come with conflicting versions and during these Joint meetings, facts are verified. There are times when the person complained against, is resistant to the process. The counsellor has to deal with that and help the counselled to counter it.

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There are instances where one person interrupts, does not looks at the woman/counsellor while talking, does not respond, tells the other person what she "should" feel, uses derogatory language, etc. The counsellor helps the counselled to understand these and assert herself. Many a times, during the course of the joint meeting, men try to hurl abuses at women or cast allegations of "bad" character on the women. The counsellor helps the woman to understand these deliberate attempts to break her support system and does not let them affect his/her judgement while handling the case. The counsellor helps the woman then to draw boundaries to prevent/curtail these displays of violence. Taking a step further, she helps the woman devise strategies to take it outside, so that she builds up her support systems.

In initial phases, especially in cases of crime against women, the perpetrators tend to deny the crime, justify it or trivialise it. In fact, if it is domestic violence, they may not even label it as crime, because battering a woman is socially sanctioned. The counsellor helps the woman confront these denials. The counsellor questions their justification, challenges the falsifications, too. At times, the counsellor also plays an advocacy role.

The pro-woman counsellor challenges the male expectations based on the traditional role models and stereotypes of women. To take an example, some men claim that their wives are not good housewives, do not look after the children etc. At such times the counsellor introduces counterculture and different ways of looking at these stereotypes, presents before the couple the alternative of men sharing the household duties and thus challenges the sexual division of labour within the family.

The counsellor, often with the help of different exercises helps the counselled to identify negative responses that create communication blockages and gives practical suggestions to improve their communications.

Significant others of both the parties are almost always involved in the intervention process. For instances, in a case of marital discord, between a couple, two responsible persons from the husband's side come to attend the joint meetings and act as guarantors so that that harassment does not recur after reconciliation.

The skills used by the counsellor are stimulating involvement questioning, probing, verifying facts, interpretation, paraphrasing, sharing insights, reflecting possible feeling, assurances, encouragement, correcting perceptions, guidance, suggestion, classification, facilitating ventilation of feelings, etc.

Community intervention

The feminist vision to create an environment wherein women can lead lives devoid of fear and violence cannot be realised without community involvement.

Involving community in individual woman's struggle, to question, challenge and counter family violence is necessary. The change after all, has to take place in all the units of society.

In AWAG, while casework is done at the curative level, the community involvement is an important aspect of the preventive work that is undertaken.

AWAG holds workshops in many urban slums of Ahmedabad. The awareness raising workshops attempt to conscientise women towards opposing oppression in their daily lives and

provide a platform for dialogue on women's issue. Information on women's organisations is also shared. As a result, women who have attended the workshops or who have got information through the women who had attended the workshops often tend to approach the AWAG field worker for help.

AWAG believes that field workers from the same background as women helpees would, if trained, be more effective as they understand the social milieu of the helpee women. Besides the field workers come to the communities daily and as a result, a follow up and monitoring of these cases is easy. Their presence at the field level causes pressure for the perpetrators of violence. Besides, since the discussions and meetings take place at the field level, the involvement of the women of the community also increases.

There is also further advantage. Some women, who attended the workshop, show an interest in the work of the organisation and want to be active. These women form their groups and act as pressure groups and help women at the community level. For instance, the women who are part of community pressure groups would provide temporary shelter to an elderly woman thrown out of the house. Or a group would confront a husband beating his partner/wife and challenge his violent behaviour.

Women who come for counselling are often invited to meetings of women's group, morchas, training programmes, film shows, etc. Their involvement in these activities helps in overcoming isolation. Women also relocate themselves in different relationships, besides the family and community based relationship.

Since the counselling centre is geographically located in the area where AWAG works at the grass-root level on other issues, helpee women tend to know one another. As a result, follow up and monitoring are easier for the counsellors.

The community, in terms of the civil society, often acts as a coercive force. At times, the community pressurises women and the counsellors to conform to the societal rules. For example, in case wherein a Hindu girl married a boy from another religious community and sought shelter from family opposition and harassment, political parties such as BJP threatened the AWAG workers too.

The experience of workers, especially women workers in dealing with violent men during the course of family counselling is that often the violence that a counselled woman faces, is also extended towards them. Some men tend to abuse the counsellor and engage in disruptive behaviour. While most men do not engage in blatantly violent behaviour, they initially tend to show contempt, derision or resistance to being called to the office, to be answerable to their wives or to be held accountable for their misdeeds by mere woman. Some men even try to hurl insults on their women family members to show that they were not afraid. The social hierarchy placing the man above women makes men balk at the thought of women counsellor labelling their perceived normal behaviour as 'aberrant'.

Thus, community, be they caste, religious or others, can at times be anti-women, for the social definition of a woman, her role and status is ingrained in our social psyche. However, while AWAG questions and challenges the community oppression of women, it also works towards creating counterculture, communities or groups of women, who create new spaces and new sense of belongings, a little away from traditional expectations.

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Paper: 7

Welfare and rehabilitation or dehumanisation?

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Violence is generally interpreted as physical, sexual and mental abuse of individuals. It can be overt or covert, continuous or sporadic but the intention in all types of violence is the same, that is subjugation of the weaker individuals, groups and communities. This paper will interpret violence as the denial of human rights, especially of women and children in state managed agencies, both institutional and non- institutional example shelter homes for women in distress, Remand Homes or orphanages for children and non-institutional agencies such as the police system and the I.C.D.S. This paper is based on the author's experience in the field of social work education and practice. It makes an effort to describe the type of violence in two institutional services and two non-institutional services offered by the government.

Reception centre for women

The author was a member of the committee appointed by the Bombay High Court in 1990 to study the Reception Centres of Deonar and Chembur in Mumbai. This order was passed by the H.C. following a public interest litigation by two organisations, that is the Mahila Dakshata Samiti and the Y.W.C.A. Mumbai and the journalist, Ms. Saroj Iyer. The petitioners filed the PIL soon after the rape of a deaf girl in one of these Centres.

Our study revealed quite a few shocking realities. Both these institutions were housed in the same premises. However, the number of residents (in-mates) in each centre hardly exceeded 30 women. The parallel set of staff seemed redundant. Yet the services offered were most inadequate.

All the women, including those who got admitted on their free will, those who were thrown out of their matrimonial homes and those who were remanded were housed together in a large ill-ventilated dormitory. The clothing and bedding given to them was most inadequate. Some were not given spare clothing.

The sanitary conditions were dismal. The toilets were right next to the dormitory. There was no water in the toilets and they were used as garbage dumps by the residents. One can imagine the stink and the danger of infections !

The food was served as per government rules. It comprised:

Breakfast:	8.30 - 9.00 -"Usal" of dried peas or gram
Lunch:	11.30 – 12.30 – Chappattis, Dal, one vegetable and rice.
Tea:	4.00pm
Dinner:	7.00 – 7.30pm – same items as for lunch.

When inspected, it was found that the chappattis were half roasted, dal was watery and the rice was half cooked. Mutton was served once a week but the residents complained that it was putrid.

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There were no recreational facilities for these women except the T.V, which was quite often out of order. In order to keep the residents busy, they were made to remove the weeds from the vacant plot on the premises but they were not given any implements. They had to use their bare hands to do this job!

Vocational training comprised knitting classes. Those who were interested were taught knitting. It was alleged that the knitting teacher secured private orders for sweaters and made the residents knit them.

As a result of boredom and extreme frustrations the women often quarrelled and beat each other. In case of fights the ayahas in-charge would sometimes beat them up.

Although medical check-up was conducted regularly, the doctor told us that some of the essential medicines were not available in these Centres. When a remanded patient had to be taken to the hospital, police van and escorts were not available for days.

None of these residents was allowed to go out. They were treated virtually as prisoners, although most of them had been admitted of their own free will.

Although it was not in the purview of our committee to investigate the rape case, we did speak to the girl who was raped when she came to visit the Centre. She wrote the name of the rapist on a piece of paper. She had since her rape, given birth to a daughter. Meena (name changed) begged of us to get her married to the rapist. He was the husband of the Superintendent of one of the Centres. He himself was the Superintendent of a hostel for tribals in the same vicinity but used to spend the nights at the Reception Centre. Meena was made to do all the household work at the Superintendents home at the Reception Centre. This case went for years and we later learnt that the accused had committed suicide in the prison.

Lack of emotional nourishment

The residents had no one to turn to in times of crises. In fact there was no one prepared to listen to their daily woes let alone the crises. It is not the lack of time but an indifferent and condescending attitude of the staff which prevented them from lending a sympathetic ear to these women.

In our report which was submitted to Mr. Justice Pendse, in 1992, we had suggested that a committee be formed to continuously monitor the functioning of these Centres.

In 1996, the Bombay High Court passed an order that the minor CSWs be rescued from brothels and admitted to governmental –aided institutions. The H.C. appointed a committee to counsel these rescued CSWs and I was one of the members of this committee. I opted for the Reception Centre primarily because it had a large number of rescued CSWs and also because I wanted to see if there had been any changes since the completion of our study.

Alas! The physical conditions were the same. There was not an iota of change. The same unpalatable food, the stinking toilets, lack of recreational activities and complete absence of vocational training. There was however, a ray of hope. The young probation Officer was doing her best to talk to these rescued girls and pacify them. The first few days there was utter choas. The girls were crying, shouting and breaking the furniture and T.V. The reasons for their behaviour were as follows:

They were suddenly removed from the brothel and admitted to the institution. There was no prior warning or mental preparation for such action. This was understandable because a prior notice would have given enough time for the brothel keepers to take the necessary steps to prevent the arrest of these CSWs.

The institutions too, were not given aany notice prior to the admission of these girls. The institutional staff was thoroughly unprepared to accept these girls in terms of making arrangements for their food, clothing and accommodation.

Some of the C.S.Ws had t leave their children either in the brothel or in the homes of ayahas who were paid to look after these children.

Most of them had no time to collect their clothes, money or other valuables from the brothel.

.As a result of frustration, some of the girls became violent. They fought with each other as also with the women police constables (WPCs). Consequently , they were locked up in the dormitory. The counselling sessions which I had with them helped them and they were pacified for the time being.

During one of their fights the WPC beat the girls with a wooden stick (not the baton). They (WPCs) explained to me that this was the only way to control them. I had a discussion with the girls as well as the WPCs and there was a modicum of peace in the Centre.

Arrangements were made to bring back the children of some of these CSWs from the brothel and from the ayahas who were employed to take care of these children. It was also possible to retrieve the clothes and money from the brothel keepers.

Efforts were made to initiate outdoor games for those who were interested. I conducted sessions on family life education, including sex education and AIDS. I was informed by the staff of the R.C. that these girls were tested for HIV, without their knowledge and 80 percent of them were positive. Since their consent was not taken prior to testing them, they were not informed about the results. In the sessions on family life education the girls told me that they knew AIDS was fatal but they did not know anything about it. Most of them said that they resigned to die so it makes little difference to them whether they die of AIDS or any other reason.

The H.C. ordered that all these CSWs be sent to the Reception Centres in their respective states. The girls cried and pleaded that they should not be sent to the RCs because that would expose them to their communities. Neither their parents nor their communities knew that they were CSWs. However, as per the HC orders, the girls from Karnataka , Andhra Pradesh and West Bengal were sent back. The Nepali girls remained at the R.C. as there was no response from the Nepali Government regarding their repatriation.

Prayas, a NGO working with the RC made efforts to supply recreational equipment for the CSWs and other residents of RC. The Probation Officer of the RC was doing her best to establish a rapport with them and was successful in doing so.

Despite all these efforts, the CSWs from Nepal resented being cooped up in RC. The unpalatable food, the dismal sanitary facilities, inadequate recreational facilities and lack of meaningful social relationships made them belligerent.

In one of the counselling sessions, they asked me three insight provoking questions:

What is our crime? Prostitution per se is not illegal in India. (Most of these girls were above 18 years of age).
We are often told that the government has financial difficulties. If so , why have we been sent to the RC? This adds to the government's expenses.
Where were all the police , government officials and social workers when we were forcefully pushed into prostitution?

All those working for the rehabilitation of CSWs need to address themselves to the above mentioned questions and evolve feasible plans in collaboration with the CSWs.

Remand homes (observation homes) for neglected and juvenile delinquent children

The Remand Homes were established at the end of the 19th century to provide safe custody and rehabilitation services to the neglected, delinquent and uncontrollable children. In the beginning of the 20th century Children's Acts were passed by various provices and later a uniform Children's Act was passed for all provinces in India. In 1986, the Government of India passed the Juvenile Justice Act to remedy the locunae in the Children's Act and to ensure a holistic approach to custodial care of neglected and delinquent children.

Despite a few lacune in the J.J. Act , it was a sincere effort on the part of the Government to reach out to children in difficult situations. However, it is not being implemented in true spirit.

Basic facilities in remand homes

Nutrition

There is a standard menu such as the one in the Reception Centres as well as the standard timings for meals. We are still in the Dickensonian era. Our Oliver too, cannot ask for more. Scant attention is paid to the needs of the growing children. The last meal of the day is usually between 6.30pm to 7pm and the first meal next morning is served anywhere around 7.30am to 9.30am. The children remain hungry for more than 12 hours.

Clothing, bedding and other facilities

The institution has to provide 3 sets of clothing, 3 sets of underwears, mattress, bed sheet, blankets, soaps etc. Interestingly, footwear does not figure in the list of basic provisions, nor do brassiers for girls. In most institutions underwears are not provided. This poses a health hazard for the children.

Recreational facilities

Except for T.V. most institutions do not make efforts to secure equipment for organised recreation. The equipment provided is broken after constant use but quick replacement is never possible in view of the red tapism in the Government.

The staff generally is not inclined to organise indoor and outdoor games. The children are left to themselves to use their leisure as they wish. Although unorganised recreation is also conducive to mental and physical health, there is a dire need for organised recreation, which is a good medium to teach values such as co-operation and discipline.

Vocational training

The stereotype vocational training is imparted to both boys and girls, e.g. stitching for girls and carpentry and stitching for boys. The institution in both these crafts is limited to catering to the needs of the institution, i.e. the boys make the furniture needed by the institution and the girls and boys stitch the clothes required by all the residents of the Home. Consequently, when they leave the Home and try to be self dependent they will find it difficult as their vocational training is very limited. In some Remand Homes, the equipment for teaching carpentry is broken and these Homes will have to wait long before it is replaced.

Neglect of emotional needs of children

Separated from their familial milieu (those with families) and catapulted in a regimented routine atmosphere of the RH. the children pine for affection. Most of the staff of R.H. complain of being overloaded with work and themselves feel deprived of due recognition of their efforts. However, the experience of social workers indicates that it is their attitude towards these children which makes them indifferent, callous and autocratic. More often than not the staff displaces its anger on to the children.

The children too, victimise those younger than them. In Bhiwandi Remand Home there was a case of a 3 year old child beaten to death by an older child. In the Mumbai Remand Home, a few years ago, a mentally retarded child was similarly beaten to death by an older boy. These incidents clearly indicate the malaise in these institutions.

The deprivations both physical and psychological, when unbearable, drive the children to displace their anger on to those who are young and helpless.

Lack of sex education and socially acceptable heterosexual relations

There is hardly any attempt in state agencies for women and children to impart sex education to the residents so as to create wholesome attitudes in them towards their own sexuality. Sporadic efforts such as experts delivering lectures and conducting discussions will not serve the purpose. The staff too, should be trained in imparting sex and family life education.

Last year a young girl was raped by a member of the kitchen staff in the Mumbai Remand Home. Soon after, there was a case alleged sodomy by a homeopathic doctor in the same Remand Home. As both these cases are subjudice, one cannot elaborate on them.

There are instances of homosexual and lesbian behaviour in most of the institutions for women and children. These cases are generally hushed up. At times those indulging in such behaviour are severely punished. There is rarely any attempt to provide counselling to these children and women.

There is hardly any socially accepted heterosexual interaction in these institutions. Girls' institutions are so insulated as not to have any contact with boys from Remand Homes, or with any other group of boys. This applies to Boys' Remand Homes and women's Reception Centres as well. As a result, the residents fantasise a great deal about love and marriage and misinterpret the kind of behaviour of anyone belonging to the opposite sex as 'love'. Such love affairs and attempts at elopement are severely punished. Despite the jails abandoning the punishment of shaving off the heads of prisoners who attempt to run away, some Remand Homes still adhere to such punishments. The girls who run away and bought back can be easily

identified with their shaven heads. They are boycotted by other residents, taunted by all and at times, beaten up.

Violence in the police system

As has been said often, India inherited the police system from the British. Hence the attitude and behaviour of the police towards the public has remained largely unchanged.

The covert form of violence begins right from the time the complainant enters the police station. The shouts and abuses hurled at men, women and adolescents are unbearable. Cases of rape in police custody are on the increase. We are well aware of the case of brandishing the foreheads of women thieves and blinding the criminals in the prisons of U.P. Although the Maharashtra police are believed to be the best in India , much needs to be done in order to humanise the police force.

The poor and the illiterate are duped and harassed more than the educated citizens. Sakhya, the Anti-Dowry Guidance Cell of the College of social work, Nirmala Niketan, Mumbai, has identified cases in which a copy of the FIR was not given to the complainant and cases in which the complainant was persuaded to file the FIR in such a way so as to benefit the culprit. To illustrate the father of a girl burnt to death by her husband and in-laws, had to file the FIR stating that his daughter was careless and hence must have got burnt while she was cooking.

In 1996 women's organisations formed a committee to look into the police atrocities in the Goli Bar slum community in Santacruz , Mumbai. Four young men who attempted to murder a local hooligan, were beaten up and paraded through the streets. A pregnant woman, the sister of one of these young men, tried to intervene and was kicked in the abdomen by one of the constables. There were types of atrocities also. We, the committee members presented this report to the then Commissioner of Police and the only immediate action taken by the police was to transfer the DCP of the area. Consequently , the Women's Centre had filed a PIL against the police.

There are numerous cases of Dalit and tribal women being stripped, beaten and paraded through the streets.

The brazen attitude of the police was well described by a social worker who took a young woman to the police station and in his presence the police asked each other *"Do you want her or shall I take her?" (Indian Express – 2.2.'93)* In 1994 some women activists in Delhi conducted an inquiry into the sexual assault by policemen on 30 women rallyists travelling in the bus (TOI – 17.10.94)

In the well known Gaund –Gawari Stampede case in Nagpur in 1994, approximately, 2000 women and children died due to the police yielding force on the 5000 people who had gathered to meet the minister. The committee which inquired into the episode found that no prior warning was given to the people before the police fired in the air and simultaneously began yielding their batons. The police mistook the behaviour of the mass as mob frenzy while in actuality, the mob had stood up as the minister's car drove in.

There are approximately 20 – 25 cases of deaths in custody per year in the Delhi Police Stations. The number of cases elsewhere, e.g. U.P., M.P., Bihar and Rajasthan may be much more but are rarely reported.

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The guilty policemen are transferred to another district or city or at most, are suspended from service. Yet how many policemen have been awarded the sentence of life imprisonment?

Violence in the integrated child development scheme (ICDS)

The ICDS was initiated in 1975 to prevent and reduce IMR and to ensure the healthy development of pre-school children and the pregnant and lactating mothers. It is focussed on the poverty group in the rural, tribal and urban areas and caters to the children between the ages of 3 – 6 years.

The Anganwadi (AW) (nursery) is the pivotal point of this scheme. The children attending the AW are provided supplementary nutrition, pre-school education and health services such as immunisation.

The administrative set-up of the ICDS is as follows:

C D P O (Child Dev. Project Officer)
↓
Supervisor
↓
Anganwadi worker
↓
Helper

Of all these staff, the AW is the most overworked. She has too many responsibilities, such as managing the AW; keeping innumerable registers, paying home visits, helping women in rural and urban areas to form Mahila Mandals (women's groups) and providing health and nutrition services to the pregnant and lactating mothers. In addition, the AWW (Anganwadi Worker) is involved in any new schemes undertaken by the government, e.g. AIDS prevention. Despite this heavy workload, the AWW is still employed as an honorary or voluntary worker. Therefore, she is deprived of a pension and other benefits. Of late the AWWs have formed unions and are agitating for their status and a substantial increase in their honorarium.

The AWWS are not well educated and are often dominated by the higher staff. There have been incidents of rape of the AWWs by the CDPOs and others e.g. at Chandrapur. A few yeaars ago, a handicapped CDPO tried to molest a Superviser. In one of the workshops conducted by the Middle Level Training Centre (MLTC) of the College of Social Work, Mumbai, we were informed that one of the Auxiliary Nurse Midwives (ANM) had had five abortions due to repeated rapes by the CDPOs. (The ANMs are involved in the delivery of health services in the ICDS).

We also learnt that the AWWs are forced to do domestic work at the homes of a few CDPOs. In one such case, the AWW was raped firstly by the CDPO and later, by his driver. This incident took place at Chandrapur district a few years ago and no action was taken against the CDPO and the driver. Incidentally, most of the CDPOs in the "progressive" state of Maharashtra are males. Most AWWs belong to the uneducated low-income groups. They are in dire need of a job. Hence they have no option but to put up with all types of violence from their supervisors.

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Violence in the health care system

This topic will probably be discussed in great detail at this workshop because most of the medical personnel present would have elaborated on this topic.

Nevertheless, based on my professional experience I wish to mention a few points. In the Municipal and Government hospitals, there is an overwhelming number of patients. The doctors no doubt are overworked. Yet, this does not justify the manner in which the patients are treated. They hardly know the effects of drugs or family planning devices prescribed by the doctors. Thanks to our government, medicines and family planning devices banned in most developing countries find an easy entry into India. E.g. NORPLANT. Till last year, when the Government of India changed its family welfare policy, this contraceptive was still prescribed in the ICMR research conducted at the J.J. Hospital.

This hospital has been in the news in the recent years for several reasons. The gangsters arrested and then admitted for health problems are in danger. Some of them have been killed in the hospital premises by the rival group.

The case of Aruna Shaanbag, a nurse in the KEM Hospital is well known. She is languishing in this hospital for the last 25 years due to brain damage as a result of attempted rape by one of the sweepers. During the riots of 1993 in Mumbai, one of the doctors of the J.J. Hospital, Dr. Aadil Chagla was beaten up by the police because he had parked his car in the compound. Mr. V.P. Singh, the Janata Dal leader was to visit the J.J. Hospital to see the riot affected patients. The police had to clear the compound for his visit and an argument between Dr. Chagla and the police ended up in Dr. Chaagla being battered by the police.

Main cause for violence in state run agencies

Lack of a people centred attitude. The governments' (both state and central) attitude towards the residents of children's and women's institutions, the patients at the hospitals and the complainants in the police station, needs to be changed drastically. It is a patronizing and condescending attitude. It is commonly said by government officials that these women and children would have been in streets but for its efforts for their custody and shelter. It is an attitude of a "do gooder" and hence gratitude is expected from the residents of Remand Homes, After Care Hostels, Reception Centres and Beggars' Homes. The assumption is that these residents should be happy and should not complain at all against any inconveniences or malpractices.

Government officials enjoy job security. They cannot be easily removed from their jobs. One of the caretakers in a Remand Home in Maharashtra makes the older children look after the younger ones, while she takes the credit and, of course, the salary. She mentioned to me that no one could terminate her services, because she enjoys job security as others in the government service.

Lack of Training to personnel working in institutional and non-institutional services. In addition to the job training there is a dire need for regular in-service training.The staff, at all levels, should be imparted education regarding the latest theories of child care, rehabilitation of women in distress, rights of the patients women and children and the legal aspects of social welfare development. The staff could be deputed for training workshops, seminars and conferences. There should be interagency and intra-agency interaction among the staff, e.g.

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case presentations, policy formulation and changes in the existing laws.. Such an attempt is being made in the I.C.D.S.

Lack of Adequate and Appropriate Supervision- The supervision of government run agencies is limited to "inspection" and that too, is limited to the financial aspects. There is hardly any educational and supportive supervision.

What needs to be done

Radical change in the attitude and behaviour of all personnel in the governmental agencies. We need to think deeply and identify root causes of poverty and destitution

Government should be liberal in funding its agencies both institutional and non-institutional. The present rate of Rs. 500/- p.m. per child in residential institutions is inadequate.

As has been mentioned earlier, there should be regular monitoring, evaluation and supervision of agency and its personnel.
Networking among the state agencies and between state and NGO agencies will yield good results.

There is hardly any documentation in state agencies. Apart from the routine registers, annual report and financial accounts there does not seem to be other types of documentation.The rich educational material regarding innovations in administration, cases handled, problems encountered and solutions utilised are hardly recorded. If the agency personnel has no time for such activities outsiders (volunteers) could be involved in this task. This brings me to the next point of volunteers.

Involvement of Volunteers: The responsibility of custody and rehabilitation can be shared with volunteers such as the senior citizens, school and college students, e.g. N.S.S. and women volunteers.The Vinamay Trust, comprising retired and others still in service in BARC is doing an excellent job of development of the children in the institution of Children's Aid Society. This Trust has now built an After Care Hostel for boys.

Introduction of Managerial Skills in the Administration of State Agencies: In order to manage these agencies effectively concepts from management such as MBO, MIS and SWOT analysis could be utilised.

Conclusion

Governmental agencies provide shelter, food and clothing to children, men and women who are destitute or those in remand. Government also offers services to the pre-school child through the ICDS and to the poor patients through its hospitals. Yet is this adequate? Even in the delivery of these services there are malpractices leading to covert and overt violence. Moreover due to the apathy of most of the functionaries of these agencies the humane approach is sadly lacking.T he introduction of yoga and vipassana may help to energise the functionaries. The Government needs to put the soul into the anatomy of its numerous services.

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Paper: 8

Mortality due to burns: An analysis of hospital data

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Introduction

The causes of maternal mortality and the various interventions that can bring down maternal deaths have been highlighted and discussed at various forums in the past few years. Awareness about these factors is on the increase amongst health care provides, health agencies and the community. All these have created an impression amongst health care providers that the major cause of death of women in reproductive age group is pregnancy related.

For writing a chapter on "Women's status and women's health," Health informative data of 1992 was analysed for demographic indicators of women's health. One of the indicators analysed was cause of death among women of the age group of 15-44 years. The data revealed that the above impression of pregnancy related deaths being the major cause of death in this group was wrong and injuries and accidents i.e., non-medical cause was actually topping the list (Table 1). Interaction with friends and colleagues from the speciality of Obstetrics and Gynaecology as well as from other medical and surgical specialities further confirmed that many medical professionals are not aware of the above facts. To satisfy the urge for further information, hospital data was analysed.

Table 1 – Caused of death in women (15-44 yrs)

	15-24 yrs	25-44 yrs
Injuries and accidents	30.94%	19.94%
Infections and parasite	17.4%	19.96%
Pregnancy related	12.66%	8.98%
Ill defined	9.50%	9.42%

Source: Health Information of India1992.

Collection of data

Data from the death register of Lok Nayak Hospital was collected for 3 months (May – July 1997) the register contained entries of those who were admitted and died in the hospital. Those brought dead on arrival at casuality were not entered in this register. Deaths due to injuries and accidents were analysed. Since burns deaths dominated the picture, data for burn deaths were collected for preceding 3 months also. An informal discussion was sought with a specialist from Burns Unit regarding these deaths being homicidal, suicidal, or accidental.

Analysis of data

Deaths in Lok Nayak Hospital for a 3 months period and deaths due to injury and accidents are shown in table 2.

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Table: 2-Deaths due to injury and poisoning (15-44 years)

	Female			Male		
	15-30ys	31-44ys	Total	15-30ys	31-44ys	Total
Burns	82	12	94	18	11	29
Accidents	3	2	5	26	10	36
Poisoning	3	3	6	2	5	7
Total due to injury and poisoning	88	17	105	46	26	72
Total deaths due to all causes	162	68	230	124	82	206

Table 3 – Deaths due to Burns (Feb-July, 97)

	<14Yrs	15-44 yrs			>45 Yrs	Grand Total
		15-30	31-44	Total		
Female	18	153	25	178	19	215
Male	17	46	17	63	13	93

Total deaths = 2030
Total burns death = 308

15-44Yrs = 829
15-44 yrs = 241
F= 73.85%
M= 26.2%

burns dominating death

Analysis of deaths due to burns is shown in table 3. Women in the age group 15-30 yrs were the major victims and 153 deaths recorded in women as against 46 in men (4 times higher) shows a strong female predilection. Interaction with the specialist from burns unit indicated that more than half of these deaths were due to accidents such as bursting of kerosene stove kerosene spilling and clothes catching fire. As to social implications of homicide, suicide or its abatement to suicide, he felt helpless and said that these deaths were already registered as medico-legal and police would have collected all detailed information and dealt with them.

Discussion

Analysis of data revealed that a large number of young women in 15-30 yrs group are dying due to injury and accidents mainly burns. Currently, medical community is either unaware or feels that prevention of such deaths are not in their domain.

Karkal (1985) after analysing data from urban Maharashtra had reported that in the age group of 15-44yrs, one in four deaths were recorded as accidents and one in five due to burns. For the age group 15-24 yrs the figures quoted were one in three and one in four respectively. She had commented that in any industry, even one tenth of this figure would have attracted greater attention and search for some remedial measures. Since victims were women, such large number of deaths were unnoticed. Also those who did not die but were maimed or disfigured were left to face the social and psychological consequences.

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Ranjana Kumari (1989) reported that 25.3% of dowry victims were dead, others were physically and mentally harassed, deserted by husband and family etc. She had also mentioned in her survey results, that in the hospital and police records, only 8 out of 38 victims were registered as murder, 29 as suicide and one as abatement to suicide. But the survey results of victim's parents showed all 38 cases were murders or abatement of suicide. All deaths were due to burns.
Number of dowry due to burns in Delhi (Ranjana Kumari 1989) is shown in table 4.

Table 4: No. of dowry deaths due to burn in Delhi

Year	Number
1980-81	421
1981-82	568
1982-83	610
1983-84	690
1984-85	558

Present analysis in a single hospital of Delhi for a six-month period has shown 178 deaths in women in age group of 15-44 yrs. Is the number of burn deaths in Delhi increasing?

Issues

- Are these deaths homicidal, suicidal/abatement to suicide accidental?
- If these were due to accidents as is presently felt by medical professionals, What are the causes of these accidents? Why and how such accidents happen more commonly in this age group?
- Would it help to record the type of stove, manufactures name, cause of accidents? Could the victim's family go to consumer court against manufacturers of stoves?
- If girls are educated regarding safe use of gloves, could such accident be prevented?
- How could medical community help prevent deaths due to burns in future especially amongst women in the age group of 15-44 yrs?
- Is there any guideline for health care professionals as to how to record these deaths to help get justice to victims or their relatives?

There may be many such issues. All of them need to be addressed and create awareness amongst medical professionals.

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Paper: 9

Torture scenario in Bhutan

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Bhutan does not have a written constitution or bill of rights. The institution of absolute monarchy with inherent feudal characteristics has ruled the country since 1907. The ruling elite constitutes a very small proportion of the country's population. The judiciary is not independent and there is no lawyer with a law degree in the country. There is no system of defence counsel. There is no freedom of speech, expression. Any one speaking for the general public and in the interest of the country, which may not suit the ruling elite, is labelled as anti-national, and may face a death sentence.

The Human Rights Movement of 1952 lead to the packing off of Mr.Mahasur Chhetri of Chirang district in a sack and was thrown alive in Sankosh river. Similarly, Mr.Garja Man Gurung of Samchi district disappeared inside a Dzong (fort) in Paro where he had gone to submit the land taxes of the district. The spiritual head of the Druka Kargyupa sect of Buddhism, the Shandrung Rinpoche, the present incarnation lives in exile in Manali in India after the previous two incarnations were brutally murdered by the Govt. of Bhutan for the sake of the power. Hundreds of people from eastern Bhutan are taking asylum in Arunachal Pradesh in India since 1962. Hundreds have disappeared for no fault of their own.

Arbitrary arrest, detention, torture, beating and flogging, starvation, overcrowding, no toilet and bathing facilities, inadequate food unfit for human consumption served once a day, incommunicado confinement for long time, no communication with the outside world, relatives not allowed to see even once, detention without charge or trial, are very much prevalent even today in Bhutan. Handcuffs or iron rods made into chains are put on the legs and hands continuously and made to work heavy manual works. Medical facilities are not made available until the prisoner reaches last stages when he is released on the verges of death so that Govt. cannot be blamed for his death in custody.

Every aspect of the life, social, political, economic and religious is totally controlled by the Govt. No social groups or NGOs exists in Bhutan to help and counsel these torture victims, as they are totally banned. The only option left is to live as such or die or flee the country. In 1990 when the Southern Bhutan protested peacefully and petitioned the king for their basic rights as Rights to Nationality and citizenship and other fundamental human rights, they had to face some consequences and ultimately flee the country to lead refugee life for the past seven years. At present over a hundred thousand Bhutanese refugees are staying in seven camps, monitored by UNHCR and Govt. of Nepal in eastern part of Nepal Since 1997 the Eastern Bhutanese are being tortured in the same way for their peaceful protest and hundreds of them had to flee the country to nearby north east India and Nepal. The Bhutanese people are living in a state of terror since 1990 with no certainty and security of their life.

Since 1992 upon pressure from the International community and Amnesty International, the Govt, of Bhutan has allowed the International Committee of the Red Cross Society (ICRC) to visit the country but they have given access to only one prison located in the capital, Thimphu.

They are allowed to visit the southern and eastern part of the country. Same is the case with the Amnesty International. Consequently hundreds of Bhutanese people are still languishing in the prison under inhuman conditions with no access to the outside world and without charge and trial. Therefore it is only the International Community, NGOs and the donor countries to Bhutan that can bring considerable pressure on the Govt. of Bhutan to allow them to visit the country to monitor the situation and ask the Govt. to drastically improve the Human Rights conditions in Bhutan. Bhutan, being one of the least developed countries in the world, heavily depends on the donor countries for her economy. India is the major donor and the closest ally of Bhutan with considerable influence upon the geo-political aspect, economy, social and cultural life of the Bhutanese people. Therefore, India has the major responsibility of solving the present refugee crisis in Bhutan. India is supposed to look and guide the foreign and defence policy of Bhutan as per the Indo-Bhutan treaty of 1949. Co-ordinated effort of NGOs, INGOs and the International community can certainly bring about an improvement in the human rights situation in Bhutan. Finally, I on behalf of the suppressed Bhutanese people both inside and outside the county would like to request the participants of this International conference, to kindly have deliberation about the situation in Bhutan and come out with a concrete proposal about the situation in Bhutan.

Torture methods prevalent in Bhutan

Bhutan does not have written constitution/bill of rights, The Judiciary is not independent and there is no lawyer with a Law degree in the country. There is no system of defence counsel. There is no freedom of speech, expression, assembly, etc. Political parties and Human Rights groups are banned. Study of Law and Political sciences is not allowed. People are exploited for the interest of the ruling elite since time immemorial.

Arbitrary arrest, detention, torture before and after arrest, beating and flogging, starvation, overcrowding, no toilet and bathing facilities, isolated confinement for long time, no communication with the outside world, not allowed to see relatives even once, detention without charge and trial, made to eat food cooked with sand, glass pieces, nails etc. are very prevalent even today in Bhutan. Handcuffs or iron rods made into chains are put on the legs and hands continuously. Medical facilities are not made available until the prisoner reaches the last stages of illness. The prisoner is released on the verge of death so the Govt. cannot be blamed for his death in custody. When national activities were planned to overthrow the government, it deployed heavy military and para-military forces in each five districts, leading to mass indiscriminate arrest of innocent villages, clergymen, arbitrary detention, looting, plunder, rape in broad daylight, torture and hunting down of Human Rights Activists even outside the country with the help of social element or unlawful means. All basic social facilities were abruptly ceased, schools turned into detention centres and army barracks, hospitals and infirmaries closed to the public. No warrants were issued for arrest. Army arrested whoever they saw and found, tortured and kept in detention without trial. Many of our friends in prison died due to inhuman treatment and torture.

Torture methods in use by the government of Bhutan

1. The most common forms of torture are severely beating and kicking. Severe beating inflicted at the time of arrest, and or in order to extract information or force the signing of a confession. Daily beating by prison guards and being forced to beat each other. Beatings were frequently done with bamboo canes or wooden sticks, rods, electric wire, belt, whips, rifle butts, bayonets, roots of trees, and thorn branches.

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2. Other forms of torture:

- Insufficient and contaminated food – mixed with small glass pieces, sand, nails etc. and not cooked properly and use of dirty water.
- Insufficient access to toilet and washing facilities – Must go to toilet at a fixed time once or twice a day and if you want at other times you are supposed to urinate / defecate in a small tins provided and kept near you to be thrown the next day.
- Starvation methods- not giving anything to eat for 3 to 10 days.
- Force statements – beating to extract the truth and to avoid this intense torture one must say whatever the Govt. wants.
- No water to drink and if we ask sometimes we are made to drink the urine or salted water, which we must drink.
- Whoever begs for water during beating and interrogation, salt poured in their mouth.
- Guards urinate on their faces.
- Often crowded – As many as 20 people are kept in a small room that is normally fit for five people, so there is no question of sleeping but must sit down the whole night.
- Defecate in their clothes or in front of others in the room.
- Washing facilities are denied completely.
- Due to living in filthy condition lice are common.
- Beating, hunger, being kept in filthy condition and no communication outside world.

Methods of torture

a.	Severe beating and kicking	
b.	Being kept in handcuffs or hands tied	
c.	Being kept in leg shackles	Leg shackles are worn continuously and they are forced to do hard labour.
d.	Detention in isolation cells	For years in some cases
e.	No light-being kept in dark with windows and doors closed	
f.	Exposure to extremes of cold	Forced to dip in river with the temp. of below 5 degrees for hours in the name of bathing.
g.	Cramped confinement (unable to lie flat to sleep)	
h.	Leg cramps	Thick plank or wood are placed above and below thighs, tightened with rope, the guards stand on the planks to increase the pressure.
I.	Made to behave as animals	Walking on all 4 limbs and made to climb on each other's backs and bull-fight
j.	Sexual abuse	Forced to perform oral and anal sex.
k.	Suspended by hands	Handcuffed and hung from hook
l.	Paraded naked in front of other prisoners	
m.	Made to stand upside down on hands for long period	
n.	Blindfold	
o.	Cut or slashed	
p.	Strangulation	
q.	Clean toilets with hands	
r.	Needle/pin under the fingernails	
s.	Submersion in water	

t.	Beaten on genital	
u.	Forced to eat beef	Hindus do not take beef.
v.	'Tuppi' pulled out by roots	
w.	Put in pit	
x.	Taking of blood	
y.	Forced labour	Prisoners are made to work from 8.00am to 4.00 p.m. frequently in freezing weather with leg shackles, they are beaten if they are slow
z.	Forced signing of confession	After interrogation and torture, most prisoners are forced to sign statements

Bhutanese victim if torture-case history

Background: Born in 1938, son of a farmer, grew up in the village like many other Bhutanese and attended local school upto 3rd class and could not continue beyond. Since the age of 22 years Mr.X took up business as his profession and continues the export of oranges, cardamom, apple, and potatoes and strengthens his socio-economic status in the village. He became a well to do middle class businessman in the district. Father of 5 children all of whom are school going Mr.X was absolutely all right with no major illness or any chronic disease. The family was happy about the situation till one fine day, when the Royal Bhutan police raided his place to arrest him. The bad days started for him, his family and all the southern Bhutanese.

It all started in Sept–Oct.'90 when the southern Bhutanese came out openly on the street peacefully to denounce the Human Rights violation and discriminatory policies of the Royal Govt. of Bhutan demanding some changes in the governance system and demanded respect for basic human rights as freedom of press, expression, assembly, right to nationality etc. (see other documents). The govt. reacted swiftly and imposed military rule in southern Bhutan converting school into army barracks and prison, closing all essential facilities and mass arrest of southern Bhutanese. Mr. X had participated in the peaceful rally. This is his mistake; he became a wanted man for the govt. and an anti-national.

Feb `91 Mr. X was busy in his business of collecting oranges and cardamom. He used to stay in a make shift camp. At night around 5 policeman raided the camp but could not find him as he was out to a nearby town. They left after inquiring from other people about his whereabouts. Next day at about 10.00 a.m., the police came and asked him to see the Dasho (district authority) and took him along with them to a nearby hotel and there was Dasho waiting for him. Dasho asked him to accompany him and took him to a junior high school that had been turned into army barrack and jail. Then they put him in a room, which was dark and splashed with blood and locked him up after tying both hands tightly with a rope. He was kept there the whole day without food and toilet. He was not beaten that day.

Next day at 9.00 a.m. He was given food in the room; it was not fit for human consumption mixed with small pieces of glass, sand and nail pieces etc. But "I was so hungry that I could have eaten vomits even if given to keep myself alive", I ate the food.

Two days later the district superintendent of police came and questioned him on why he had come here? Did I make any bomb? He also asked him to show the place where bomb had been made and to name other people who are involved, and help the Govt. to arrest etc. He replied that he was not aware of any such thing about the rally and others. Then the DSP blasted him saying that he was anti govt. and not in favour of the govt. and levelled him as an anti national. He took his statement and left.

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Next day the head of RBA stationed at Damphu (district HQ) Mr.Cimmi Dorji came with the statement and read it. He called one of his friends also arrested for same reason, untied the rope on his hands, asked him to bend down and asked his friend to beat heavily on his back with big cane. After few canes X could not bear it and passed urine in pant and defecated too. After this he was asked to tell the truth. Out of beating that X got for the first time in life, X got furious and with the tied hands tore off his shirt and asked him to shoot and kill. He replied that he can kill him and many others at least 15-20, and the govt. will do nothing but promote him to higher rank then X- repeated his version again. He locked him up and went back. For the next 4 days X was not touched.

Mass arrest was going on in the village, so every day hundreds of villagers were brought and tortured, and the reign of terror dominated the day and night. They would bring somebody unknown to him and ask why he was brought here. When X used to reply that he doesn't know then they used to beat with rifle butts, sticks, wires, etc. regularly.

After 2 days one high-ranking officer from Thimphu came and asked what X has done and started beating with canes on his head. X bled and fainted. Then he hit on his knees. After that it became a routine once in 4 days.

X was allowed to go to toilet with guard and tied hands once in the morning and once in the evening. In between if needed a small tin was provided to pass urine and kept near to be thrown next day. Fourteen of them were kept in a small room normally fit for three people only. They had to sleep on the cemented floor without any clothes, rather sit the whole night dosing off as the room was too small for all of them to sleep.

Food as described earlier (once or twice depending on their mood), starvation, beating, no bathing or shaving, hands tightly tied together, no medicine, no news of what is happening outside, whether family members are dead or alive and continuos addition of innocent villagers went on for 6 months. No friends, well wisher, journalist, or family members were allowed to visit/ see us.

They were regularly asked to hit each other, fight-cook fight and bull fight, made to stand on one leg for hours, perform different sexual acts on each other, forced to drink urine if asked for water, eat like animals and iron. X was like others beaten on the sole, ear, and genital area. Regular pin pricks under the nails; hanging upside down etc. had become the routine activities of his life. By now X has become immune to these tortures and his body had become pain insensitive.

After six months of intensive torture, the police shaved off the hair and beard and the next day loaded them in army trucks and were taken to Chemgang central prison near Thimphu where the normal temperature remains below –0 degree Celsius.

"Before we entered the central jail at Chemgang Thimphu our handcuffs were removed and iron rods of 2-3kgs. moulded into chins were fixed permanently on the legs about 5 inches apart".

The life in Chemgang became relatively easy as it was more of manual and mental tension rather than harsh beating though beating was regular if they could not work as per their direction. Daily routine included, Jogging bare foot in the morning with chains intact and on the snow, heavy manual work from 7 a.m. to 5 p.m. that included breaking big rocks with small

hammer, uproot trees with spade, carry big logs and stones, dig vast area of barren land. Food used to be given on the will of the authorities and if they are not able to do the work then they used to be starved.

Apart from this, they had to entertain the guards by singing, dancing, and fighting performing different acts that are not done normally or are impossible to perform. Sexual acts as sodomy was a regular feature and had to be performed in front of all. If they deny these then the guards would hit with whatever is available and hang upside down. Once while X was eating the contaminated food the guard hit with boots on his face saying that this was the beer and fried chicken that X used to eat on business trips. "Profuse bleeding from nose with no water to drink and the pain was one of my worst experiences in the custody".

They had to go to river once in fifteen days to take bath. The temperature would be below –0 degree Celsius and the water frozen. They were supposed to dip in the water. One of the prison inmates died in the custody due to the torture meted to him in front of X. Medical facilities are not given even if you are dying. No communication with outside world-newspaper, radio, visitors and relatives were allowed at all.

After six months in the central prison, 313 of them were released on condition that they leave the country after signing the necessary Govt. documents. X had never thought that he would come back alive from the prison to meet and see his family and friends. But then he realised that it is not easy for human beings to die and God helps for the truth. X came back with all torture, and by now X was not able to walk straight, sit straight, talk normally, suffers loss of memory, hypertension, frozen body in the morning, burning feet and hands and physical deformity around the hip joint.

Back home the local authorities began to haunt him asking him to sell his orchard and land to them at a normal price and if not face the consequence of re-arrest and torture. At first X denied flatly but then the pressure increased from all the corners. Ultimately to save his life and his family X was left with no alternative but to flee the country.

At present X is dwelling in the refugee camp along with his family where he is getting the treatment for Hypertension, frozen body and other symptoms. Despite the treatment given to him by CVICT (KTM) in the initial years and now by the SCF (UK), there is no sign of improvement and relief for him. It looks that X is crippled for the rest of his life and will die from this suffering. He can't wake up in the morning and can do no productive work. Burning pain in the sole and hands remains day and night.

CEHAT, Mumbai, India

Paper: 10

Population Control
State Sponsored Violence Against Women

Malini Karkal
Mumbai, India

The planet is getting polarised in demographic and economic terms. Developing countries experience problems with their population growth along with pervasive poverty. Demographic projection of population raise questions on the ability of the earth's carrying capacity to maintain people at adequate standard of living. Inspite of the overall improvement there are wide variations in the quality of life of people. High rates of growth of population therefore certainly need to be contained. Thomas Malthus in 1798, exactly two centuries ago, had warned about maintaining the balance between population and food-supply unless population size was controlled. The population in these two centuries has grown six fold - from one billion to six billion. Food available in the market is enough to feed all, and on this count Malthus is proved wrong. If people still go hungry it is because of absence of distributive justice in the prevailing social system. Similar situation prevails with respect to other resources.

The problem of having adequate resources is not necessarily a problem of the future. Many non-renewable and renewable resources are already being used in an unsustainable manner and consumption is more than the earth can regenerate. Available information indicates that the economic inequity among people is very rapidly growing. A fraction of the world's people consume disproportionate amount of natural resources.

During the pre-independence period, national leaders active in movements for improving the life of the people in general and those working for the welfare of women, such as the All India Women's Conference, had discussed the health problems faced by the women and the children. Some of the elite, who were exposed to Malthusian thesis on population set up Neo-Malthusian Leagues on the lines of those functioning in England and Europe to warn people on the dangers of large size of population. First such League was established in 1929, in Madras City. Similar Leagues were established in Pune and Bombay. However the data available from the censuses had shown that the rate of growth of population was low. During 1911 and 1921 the population had actually declined from 252.1 million to 251.3 million because of high mortality. Health of the people was a major problem.

Professor R. D. Karve, who was the main motivator for the work of the League in Pune, was convinced that to improve the health conditions of the people the conditions of women needed to be improved. He also realised that the poor conditions of women were both products of their neglect and results of the problems such as high morbidity-mortality in the society. To improve the conditions of women, among the issues he dealt with were, child marriages, widow remarriages, access to knowledge on sexual health and availability of contraceptives to regulate child bearing. Dr. Karve started a magazine named Samaj Swasthya that discussed issues of social well being. It advised men and women to use contraceptives so as to make men see reason in taking their share of responsibilities in parenting a child and prevent unwanted pregnancies thereby reducing incidence of induced abortions.

The Bhore Committee set up in 1943 to asses the health situation in the country, submitted its report in 1946. The Committee recommended setting up of the health infrastructure that would

promote preventive health through Primary Health Centres (PHCs) spread to cover entire population. Incidently, the WHO Assembly held in Alma Ata in Russia, which suggested Health for All, had the same principles for designing health services. Bhore Committee had also suggested the need to control population. In the First Five Year Plan (1951-56) of the independent India, provision was therefore made for a Family Planning Programme. It is to be noted that similar work of guiding couples to regulate fertility, so as to liberate women from the cycle of pregnancies and deliveries, carried out in England by the Planned Parenthood Federation, was called Birth Control. Indian programme which had the aim of health of mothers and their children was named Family Planning.

The programme came in operation in 1952. India became the first country to accept fertility regulation in the national programme. A sum of Rs.6.5 million was provided in the First Plan. The Programme was to provide services for care during pregnancies and during the post-natal period, and motivate couples for regulating fertility in the interest of the health of the mothers and their children. Advise and services for contraceptives as well as research was also included in the programme. Since family planning was a part of health programme a cell was created in the office of the Director General of Health Services.

The number of family planning clinics rose from 50 in 1951 to 156 in 1956 - end of First Plan and to 4,134 by the end of Second Plan (1956-61). To assure that services were available to all the couples the clinics were spread through the rural as well as the urban areas.

"Based on a mathematical model, Coale and Hoover showed that, with the rate of growth of population experienced by India, in 30 years the per capita income would be lower by 40%. Coale and Hoover's work stimulated interest in economic-demographic relationships of populations. A large number of Western writers highlighted the public sector costs in Third World countries of supporting rapidly multiplying numbers of people. Among the areas that were to be affected were: education, health, job opportunities, income distribution, food, other resources and effects on environment. Leff analysed data from 74 developed and developing countries and concluded that higher fertility increases dependency burden and adversely affects saving rates." (Karkal Malini, 1989, Can Family Planning Solve Population Problem? Stree Uvach Publication, pp.24-25)

"In the light of the growing concern about the growth rates of populations, the General Assembly of the United Nations carried a resolution in December 1962 asserting the relationship between population growth and economic development. The Assembly authorised United Nations to take steps designed to provide assistance in population problem. Simultaneously the Government of the United States of America issued a Statement of United States Policy. The Statement expressed concern about the population trends and offered to help other nations." (Karkal, 1989, ibid, p.25)

The year 1965 saw famine in the country. There was shortage of rain the following year too. India experienced a food crisis, and the United States government discussed the food shortage and population situation in India. The U.S government sent Dr. Jack Lippes with the new method - Intra Uterine Device (IUD) - a female method that he had developed. The method was promoted saying that it was simple, inexpensive, easy to use and `one-time-motivation' method that can remain in situ for a long time.

In 1962 Indian family planning programme set for itself a demographic goal. To achieve the goal, for the first time target for the programme was set at achieving a birth rate of 25 by 1972. K. Srinivasan says, "With the setting of the Demographic goals for the programme and

achievements of these goals being made the responsibility of the health departments, the programme became entrenched in a HITTS model: i.e. Health department operated, Incentive based, Target-oriented, Time-bound and Sterilisation-focused programme." "In my view 1962 was the beginning of HITTS approach which lasted until 1972 with varying degrees of emphasis on each of its components of involvement of health functionaries, change of incentives, targets and the time-frame for the achievement of targets, leading to the 'coercive approach' during 1976-77". (K. Srinivasan, "Population Policies and Programmes since Independence: A Saga of Great Expectations and Poor Performance", Demography India, Vol.27, Number 1, January to June, 1998, p.6)

"During the Third Plan (1961-66) the programme expenditure increased to Rs.248.6 million, 11 times more than the Second Plan. It was again raised to Rs.704.6 million, almost three times the expenditure during the five years of the Third Plan. Expansion of personnel at the PHCs and Urban Family Planning Centres occurred rapidly to pursue the HITTS model. (Srinivasan, 1998, ibid, p.6) The budget provision for family planning during the Fourth Plan was Rs.3150 million. "The infrastructure was considerably expanded and there was a strong desire on the part of Government of India to resolve the population problem once and for and for all by intensifying on the HITTS model by organising vasectomy camps on a mass scale." (Srinivasan, 1998, ibid, p.6)

In the camp-approach the staff of the local clinic motivated couples who gathered at a nearby place on an assigned date. The services of city doctors, who were perceived as professionals were made available at these camps. The financial incentives at the camps were larger than the normal ones. Group pressure and mass motivation worked at these camps to bring in a large number of individuals. The success of the camp depended on the ability of the organisers to collect people. The largest camp was organised in Ernakulam in Kerala in July 1971, where a total of 6,26,913 men underwent vasectomy. (Krishnakumar S., 1974, Ernakulam's Third Vasectomy Camp Using the Camp Approach, Studies in Family Planning, Vol. 5, No.2, February, pp.58-61)

"The law on abortion was liberalised to further reduce the birth rate. However, in spite of the promotion of terminal methods such as sterilisation, and making abortions easily available, the birth rate at the beginning of the Fifth Plan (1974-79) was 33 per 1000 population. It was therefore decided that the programme should be carried out more vigorously. The demographers who were responsible for estimating the number of couples that had to be `protected' (from pregnancy), decided that the target for achievement during the Plan period should be 40 to 42 million couples. The number of couples who had been `protected' during the Fourth Plan was 15 million. Obviously the pressure on the staff and other government officials to meet the targets, increased." (Karkal Malini, 1998, Family Planning and the Reproductive Rights of Women, Understanding Women's Health Issues, a Reader edited by Lakshmi Lingam, Published by Kali for Women, p.169-70)

"Till 1970, female sterilisation could be performed only during the post-partum period. But to decrease the number of childbirths, a terminal method that ensured that the couple would have no more children was needed. This was vasectomy or the sterilisation of the male. In patriarchal societies it is never easy to get men to take the responsibility to ensure that family is not burdened and the health of women is not strained. Under these conditions, the men who could be operated upon were poor, especially from the rural and tribal areas". (Karkal Malini, 1998, ibid, p.168)

CEHAT, Mumbai, India

The then Prime Minister, Indira Gandhi, believed that there was a desperate need to control the size of the population. In her address to paediatricians, she said, "To bring down the birth rate speedily, to prevent the doubling of our population in mere 28 years, we shall not hesitate to take steps which might be described as drastic." (Goverment of India, 1976, Background to the News. Mrs. Gandhi's inaugural address to the 31st Conference of the Association of Paediatricians of India, New Delhi, Ministry of Information and Broadcasting, 22 January)

"The family planning programme in India went through a traumatic phase during 1976-77. With the declaration of a state of Emergency in the country, a national target of 4.3 million sterilisation for the period April 1976 to March 1977, was announced. The sterilisation programme was implemented with coercion, especially in the northern states where the achievements in earlier years were relatively poor. The brunt of this was borne by the poor, illiterate, lower castes, scheduled castes, and Muslims. Since the programme had become target-oriented, the staff was threatened with punishments such as stopping of their increment or cutting salaries if they did not meet the targets given to them. During the Emergency, the abuse of clients and the implementers, was widespread." (Karkal Malini, 1998, ibid, p.170) The number of sterilisation done during April 1976 and March 1977 was 8.26 million, more than the number done in previous five years and more than the number done at any time in any other country in the world. Inspite of the excesses, the target of reaching the birth rate of 30 by the end of the Fifth Plan, was not achieved.

Demographers, supported the achievements of sterilisation programme conducted during the Emergency. Means used to achieve the targets for reducing birth rate, and the impact on the lives of common people, was none of their concerns. Inspite of strong evidence that mere reductions in birth rate cannot assure better life for substantial proportions of the population, demographers argue for demographic transition as an objective to be achieved at any cost. K. Srinivasan, a well known demographer and ex-director of a World Bank project, ex-Director of UN-GOI Institute for Population and now Executive Director of Population Foundation of India, praises the achievements of the coercive programme during the Emergency. Commenting on the slowing down of that programme due to strong national and international criticism, he says, "From a retrospective analysis - it seems that India made a sacrifice in terms of delayed demographic transition, and possibly socio-economic development to safeguard her people's democratic rights. It is doubtful whether a compulsion in family planning programme can ever be implemented in India within the present political structure or that centrally specified demographic goals can be imposed on the States." (Srinivasan K., 1995, Regulating Reproduction in India's Population: Efforts, Results and Recommendations. Sage Publication, New Delhi.

Srinivasan is not alone in providing moral support to coercive family planning programmes. There are other demographers who hold similar views. Among them is Ashis Bose, Founder Member of the Indian Association for the Study of Population. Bose says, "The main reason for the success of the Indonesian model is the excellent military style logistic in running the programme. In India we have an overdose of democracy. (Bose Ashis, 1994, Tamil Nadu's Successful Demographic Transition, Financial Express, January 4.) It is therefore not surprising that the population policy drafted by the committee chaired by the agricultural scientist, M. S. Swaminathan, and of which Bose was a member, had suggested use of army for implementing the Indian family planning programme.

The target of the programme so far was the birth rate. Seeing that in-spite of implementing the HITTS model under the guidance of the demographers, birth rate had not shown a reduction to the desired level. The Sixth Plan aimed to reduce the family size to 2.3 with net reproductive

rate (NRR) of one, i.e. limitations on the number of daughters a mother was to have, to be achieved by 1996. Obviously the underlying logic of the goal of the Plan was to reduce the number of women - the child-bearers - in the population. The Plan aimed at CPR (Couple Protection Rate) of 60% sterilisation during the plan period was to be increased to 22 million. In addition 7.9 million couples were to be protected through IUDs. During the Sixth Plan (1980-85) an allocation of Rs.10,780 million was made in the sector of family welfare while actual expenditure was Rs.14,480 million.

Since the voluntary response to the programme was poor, and infant and child mortality continued being high, and it was believed that acceptance of family planning depended on survival of children, a programme of Child Survival and Safe Motherhood (CSSM) was started with funding from the UNICEF. All along mothers and their children were considered together under the Mother and Child Health (MCH) programme in operation as a part of the normally provided health services. The new programme separated the mothers from their children when the fact is that the health and the well-being of the children was dependent on the health and the well-being of the mothers.

Thus the programme that was started with the objective of welfare of the women and children became a population control programme with demographic goals and its targets became women. Mainstay of family planning now is sterilisation and largely of women. And to have larger impact on the birth rate, interests are to sterilise women at young ages. National Family Health Survey (NFHS), (International Institute for Population Sciences, 1995, National Family Health Survey 1992-93) which collected data from 99% Indian population, reports that the TFR (average number of children a woman is estimated to bear) has declined from 5.1 in 1971 to 3.39 in 1992-93. This has been achieved by increasing the proportion of couples using contraceptives from 10% in 1971 to 44% in 1992. More significant is the fact that 84% of the total users are using terminal method such as sterilisation and 88% of the sterilised are females. The average age of the women among the sterilised is 26 years and in the States of Andhra Pradesh, Maharashtra and Karnataka, it is as low as 24 years. It is also important to note that majority of the sterilised have never used any temporary method before going for a terminal method such as sterilisation. Thus raising doubts about the women's role in the decision to accept the terminal method and the methods used to promote population control.

States of Bihar, Madhya Pradesh, Rajasthan and Uttar pradesh are known as BIMARU States because of their lower acceptance of family planning and higher TFR. NFHS however shows that irrespective of differences in TFRs, the number of children age five is about 2.6 in all the states including the BIMARU states. Further, the Registrar General (RG) of India reports that 37.3% of total deaths are to children under age 15 years. This percentage for Bihar is 41.5, for Madhya Pradesh it is 45.3, for Rajasthan it is 45.4 and for Uttar Pradesh it is 47.7. There is evidence that high mortality among the young is closely linked with the health of the mother and their status in the society.

NFHS also shows that every third child born in India is handicapped at birth as it is born with weight 2500 grams or less and has not had opportunities for the full expression of the innate genetic potential for mental and physical development. The data also shows that order birth does not make much difference to being born low-birth-weight, indicating that limiting number of births is not a solution to the problem of quality of the health of the children born. Such inequality is the cruellest form of social inequity.

Among the reasons for the high incidence of low-birth-weight babies, high infant and child mortality as well as high maternal mortality is the child bearing at young ages. Though there is

a law prohibiting marriage of girls till age 18, NFHS data show that about 5% of the girls in ages 10 to 14 are married. This percentage for the age-group 15 to 19 is 36 (rural areas it is 41%). (The data provided by C.P.Prakasam of IIPS)

Maternal mortality rate (MMR) in India is one of the highest compared to several other countries. NFHS reports 437 deaths for rural and 397 deaths for urban areas per 100,000 mothers. This implies that 100,000 women die each year for causes related to pregnancy and childbirth. Other studies show that per loss of a mother due to death there are about 16 who suffer serious damage to their health. Post-mortems of mothers, in a hospital in Bombay, had shown that even when the death certificates showed that the mothers had died due to direct obstetric causes, majority of them were diseased and had poor health. It is to be noted that 73% of the deliveries take place at home and are conducted by traditional birth attendants (35.2%) and by relatives or friends (29.5%), and counting even the minimum ante-natal care 68% of the mothers received ante-natal care. (IIPS, 1995, India Report, pp.239-240)

Analysing NFHS data, Raju (Maternal and Child Health Services, 1997, The Indian Journal of Social Work, Volume 58, Issue 3, July, p.417) reports, "The analysis indicates that MCH services are probably reaching often to mothers who are potential cases for sterilisation. The reason seems to be that there is a lot more emphasis on achieving family planning targets, and MCH services have become a means to achieve the targets as these services form a part of overall family planning programme."

Despite cuts in most areas of public expenditure, including health, the government's budget for family planning has increased from Rs.3,200 crore for the five-year period 1985-1990 to Rs 1,000 crore for the one-year period 1992-1993. The UNFPA has increased its assistance from US $52 million for 1985-90 to $90 million for 1991-95. By 1995, the population growth rate is to be reduced from 2.1 percent to 1.76 percent and the crude birth rates from 30.5 to 26.7 per 1,000 population. The use of contraceptives is to be increased from 43.3 per cent to 53 per cent. USAID has given financial assistance of US $325 million for decreasing the total fertility and mortality levels, from 5.4 to less than 4 and increasing couple protection rates from about 35 per cent to 50 per cent by the year 2000. This is largest programme of foreign assistance for reducing population growth rates that the country has ever embarked upon.

Women's movement has gained considerable clout. United Nations has now accepted an NGO Forum as a part of its major conferences. At the conference on environment held in Rio in 1992, and at the human rights conference held 1993 in Vienna, women vehemently opposed the move to blame the problems on rate of population growth. Before the International Conference on Population and Development (ICPD), scheduled for 1994, women organised strong international networks that argued that the population control programmes were anti-poor, and anti-women. They pointed out that the consumerist life-style of the 20% minority of the world's people was not only creating shortages of resources but was causing irreparable damage to the environment.

The Program of Action (POA) of the International Conference on Population and Development (ICPD) officially condemned the practice of quotas and targets and other ways of measuring the success of family planning programmes by the number of users of so-called "modern" contraceptive methods. POA stated, "Government goals for family planning should be defined in terms of unmet needs of information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients." India is a party to the decision. But the condemnation on paper has not meant a change in the behaviour.

CEHAT, Mumbai, India

There is a growing feminisation of poverty in India. Gender equity and free and informed choice for women are critical for empowerment of women. There is a need to shift the burden of family planning from women and aim to foster a "culture of joint responsibility of the couple." There is also a need to emphasise the problem of women's status as such in the family, the dynamics of control, domination and violence against women that characterise the working of the family and the lack of access to an independent income, that most women suffer. Coercion and consent, of economic power, and cultural authority within the family are used to secure and perpetuate the subordination of women. It is clear that unless a working model of the various types of families and their dynamics is posited, notions of `joint responsibility' cannot simply be realised in practice, nor can policies and programmes be sufficiently sensitive to the needs and rights of women and children.

"The major focus of most human rights institutions that deal with procreation and reproduction is on family planning, which is equated to limiting births. The broader issues of health care, economic resources and social security, to say nothing of freedom from sexual abuse and discrimination, remain unaddressed, though these conditions are directly related to women's lack of reproductive self-determination. The policies that demand maternal and child health have essentially emphasised the child, women remain unspoken word. The starting point of reproductive rights has to be health, well-being and empowerment of women. The needed approach to reproductive rights has to be women-centred and social change oriented with an emphasis on health issues. This means top priority to reducing women's morbidity and mortality related to reproduction and sex, as well as maximising the conditions that make authentic choice - whether to have a child or not - possible. Under the present situation, such demands mean women walking a thin line between women's need for services and their need not to be controlled or coerced by them. A woman's self-determination is an intrinsic part of her dignity as a human being. Whether anti-natalist or pro-natalist, population policies tend to treat women's bodies as the instruments of male-dominated populationist ends." (Karkal, 1998, ibid, p.177)

CEHAT, Mumbai, India

Paper: 11

Lesser humans
Scavengers of the Indian republic

Martin Macwan
Navsarjan
Ahmedabad, India

Introduction

Three Years of working with the scavengers

So much has been written on and around the issue, including reports by the various commissions set up by various governments. Hundreds of recommendations have been made and schemes drawn up, without ever being serious about it. If fifty years of national independence have to be summarised by the scavengers (*bhangis*), it is very simple. "They trust no one."

Therefore, I do not wish to add any more material to the subject, which is theoretical and impotent. The nation has patted its back several times for evolving various plans and felt content, in spite of knowing that their inaction has only strengthened the privileged. So, if we can not wipe someone's tears, why to deceive them with promises that have been violated several times.

Personally, it has been a shock to me. In spite of working with *Dalits* for many years, this issue never hit me hard until about two years ago. I only wish to narrate here the facts that I any my colleagues have come across. These facts throw light on the life of scavengers. I feel, these facts tell a story of scavengers, but more than that it tells the story of the State, which has maintained a status quo.

These are facts that describe the scavengers as they are today. Any attempt to theorise these facts only helps to wash away the guilt of those who are in public life.

If they are only an embarrassment to the nation and its leaders, I wish to increase it. These are hard realities that exist today in 1998. They affect around 8,00,000 families in India.

Part-I: Forced labour of the filthy kind

1.1 Dry latrines have to be cleaned.

Vado Varvano Chh.

There are various kinds of dry latrines in both the urban as well as rural areas. These units are either private or managed by local self-governments.

1.2 I still have to clean up the waste

Vassida Varvana Baki Chh.

Vassida means dung of animals, along with other filth that is scattered all over. They need to be collected and dumped at a designated place. The village has sizeable number of cattle. The dung mixed with hay is dumped at a site to make manure. The excreta of very young babies is also mixed in the collection. Vassida is collected manually into shallow plates made of tin and

dumped. The dumping grounds are often near the *Bhangi* houses. After the dumping is over, the tin plates are cleaned with hands by mixing dry soil to wipe off the sticking content. This is to save the plates from corrosion. Some food is given to them daily. At the end of the thrashing season, they are given 10-15 kilos of grain.

1.3 Vadoliyu: There are communities like feudals and Muslims, who are considered high caste but are poor. Their women live in enclosures. Curtailing women's freedom has forced them to a small dry latrine known as Vadoliyu. There is a hand dug small pit in the ground, not deeper than one foot in which human excreta is discarded. It has two bricks, one on either side to serve as a footrest. The privacy is created by four wooden pillars posted around the pit, covered with pieces of jute bag as walls.

1.4 Dabba jajroo: The rich in the village build a proper toilet, which is at the end corner of their castle like house. The toilet has everything but a tub replaced below with a tin box, removable from an outlet built in the wall only from the backside. The removal of this box can not be seen from the inner part of the house.

1.5 Gutter Latrine: The open gutters for disposal of filth are connected to every house with bathrooms. The children and even adults in the darkness defecate directly in these gutters, where excreta mixes with plentiful of dirty water and other filth.

1.6 Vada jajroo: In every big village the local government demarks a plot of land, each separate for men and women to be used as open toilet. The plots are covered from all the sides with a three to four foot high wall, with an open entrance at some point. In a larger village there may be several such wada latrines.

1.7 Khada Jajroo: A properly built latrine is connected to a soak pit at the backside. The bathroom is also connected to the pit. The mixture of water and excreta never leaves the pit dry. When the pit is full, which is neck deep, the person who cleans gets in the pit. For a period of three to four hours he remains in the pit covered with filth up to the neck.

1.8 Village Community Latrines: These are of various kinds. There is one set of properly built latrines, without tub, leading disposal through a hole to the common open drain at the backside.

The other kind comprises of a place like a big hall, with two rows of toilet place, one opposite the other. The distance between the rows, which are raised above the ground by one and half feet, is approximately three feet. Only two footrests divide one person, sitting next. People, who utilise this, come with only one small tin of water, to wash themselves. The disposal remains right there, which is collected with two tin plates and emptied in a bamboo basket, for disposal. Basket is either carried on head or shoulder. At times, basket can be full with worms, which breed very fast, in the waste leaving indisposed for a day or two.

The only people, who dispose human waste, are *Bhangis* or the Scavengers. Most of them are women. Their day starts very early in the morning with foul smell of shit and the day ends with the same foul smell as their houses are close to all forms of latrines.

The owners of private dry latrines pay them Rs. 5/- per month (12 US.Cents) and a piece of bread everyday. The piece of bread can be seen hanging in front of their belly tied in the sari, while they keep themselves busy working, hands soiled with filth.

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The local Self-Government, who employs the, through State Government grants, does not follow uniform standards of payment. Some bodies pay Rs. 50/- per month (Us. $ 1.25) while others pay Rs. 600/- a month. In some cases, the salaries are not revised for past 20 years or more. In semi-urban areas, payments are higher, although there is unequal payments for men and women. The grants used for these payments through the Self-Governments are part of the World Bank loan given to the Nation under various development programmes.

The workload never decreases, because it is linked with population increase. So, when mothers are sick, unable to work and at the same time cannot afford to take leave, the children join them as a helping hand. The children then face seclusion in schools, where other children and sometimes teacher smell stink from them.

1.9 You drag away that (dead) dog
Aalya, Kutru Dhahaidi Kadh
There are some animals, which are useless after death. They are also considered inauspicious. Dogs and cats are part of this category. Many Hindus shall return home halfway, if the cat crosses their way. When cats and dogs die, they have to be discarded. Members of *Dalit* community, other than *Bhangis* are summoned to discard such animals, only where there are no *bhangis*. They have been incidents of physical attacks on *Dalits* for their refusal to do so.

The dead animal is tied with a stings and then pulled away, out of the village, while all others who are passing by shall go off the road with their hands covering their nose and mouth, to save themselves from the foul smell, that may bring impurity, leading to a bath.

1.10 Railway Tracks and Excreta: Even when the trains stop at the stations, there are some passengers who continue to defecate. Excreta, in this case, are trapped between rubble stones. The only way to remove it is by scrapping with wire brooms.

1.11 Manholes: The metropolitan and big cities have flush latrines connected to sewage lines, very big in size. When they are blocked, the scavenger through the manhole gets in it, and dives in the filthy water with a bucket to remove all kinds of substance, such as plastic, cloth, glass pieces, etc. In the industrial pockets, the chemical waste is channelled to these gutters or they seep into the same as they do with ground water.

In Ahmedabad, Gujarat thirty-two people were reported dead during past two years, while in the manhole, having inhaled Carbon Monoxide.

1.12 Pathological Laboratories:
The stool and urine for tests are collected from the patients by a *Bhangi* only.

1.13 Post-mortem Rooms: The dead bodies are handled by *Bhangis*. The opening up of the dead body is done by a *Bhangi*, so is the job of sewing the dead body after the autopsy. In a murder case of a *Dalit*, where the body was exhumed after seventeen days, I witnessed that the Doctors were at a distance taking notes. The cutting of the body breaking the skull, removing bones for examination was done by a *Bhangi*.

1.13 Hospitals and Maternity Homes: Removing blood, urine, shit stained bedclothes is done by *Bhangis*. Cleaning scavenge from the bodies of the patients undergoing ailments or removal of waste and urine pans and cleaning them is done by *Bhangis*. Tables in labour rooms of

maternity homes are cleaned by *Bhangis*. The hospital jobs are carried out by women. They are referred as 'Mahetrani'.

Part-II: traditional duties in villages: Not by choice but enforced by custom, tradition and imperatives of survival

2.1 Go, Make the announcements
Haad Padi Aav (Town Crier)
In villages this medieval mode of communication is still popular. The *Bhangi* is asked to go from street to street and announce a meeting or warning cattle breeders for trampling of crops etc. In return he is paid a rupee or two.

2.2 Toran, Dhol and Dakla
Tying buntings – festoons (Toran) of tree leaves over the doorway, and cloth shade (Mandap) in front of the house having a wedding, or on festive days like the New Year day. Playing drum (Dhol) during wedding celebrations lasting for a couple of days among all the castes of the village. Playing the small drum (Dhakla) along with wailing – like singing during the worship of the exclusive deity of the other sub-castes of *Dalits*.

A *Bhangi* does all jobs. The payments are in cash and kind. Such jobs done at wedding ceremonies can earn better money. Denial to perform any of the jobs can lead to serious consequences.

2.3 (Go, give the bad news about the Death)
Ja melo Aali Aaay
News is of two kinds, good and bad. News about Marriage, Engagement, Childbirth, especially of Male child, newly wed girl getting pregnant for the first time are considered good news. News about death, especially of young is considered bad news. The person who gives good news is auspicious. The person who gives bad news is the contrary. People in the rural areas communicate largely through personal messages.

Good news therefore is sent through only Brahmins. (Brahmins are priests. Even *Dalits* amongst themselves have a sub-caste of Brahmins). A *Bhangi* only gives the bad news. In return of his service, he is given some butter, jaggery and bread. He will normally carry a bathing towel, which he will spread on the ground and sit after the news is delivered. The relatives of the dead shall empty a cup of coarse grain in the towel. So far as the eatables are concerned he shall borrow a utensil from his local caste man and get food in it.

He might sit there in a corner off the road and eat his given food or carry the same back home for his family.

Part-III: Some traditional practices: Internalisation of degradation

3.1 Eating evil or cursed food
Varelu, Mantrelu Khavanoo
Belief in many black magic rituals persists among the rural and urban (non-*Bhangi*) poor of the so-called lower, and middle castes, sometimes including so called upper castes. For example, black magic treated food is left at the nearest crossroads to free a person from evil spirits. No one touches that food – offering. Except of course the *Bhangi* who eats it as part of his life-long struggle to fight the hunger.

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3.2 Masters, Please give us dinner

Vadu Aljo Maa Baap

Vadu, means dinner. Aljo, means "please be kind to give'. Maa Baap, means mother and father literally but in this context it means 'Kind Masters'. Whether it be a city or a village, in the evening time approximately when one is about to finish the dinner, a person mostly a woman, sometimes accompanied by a child, enters the street. Both are carrying aluminium utensils. She would then shout with maximum humility. "Vadu aljo Maa Baap." At some distance the same appeal is repeated and then meekly they go to a central place and wait. Both are barefoot. The woman has a bigger utensil and the child has a smaller one, for solid and liquid food respectively.

One after another some member from the family, mostly women and kids come out with food, and from a little distance shall empty the food in the utensils held by the woman and the kid. Every time that someone comes, the woman plays two functions. Firstly, to accept the food with expression of thanks in the eyes saying, "lao Maa Baap" (Give us kind masters) and secondly be vigil that her child does not even by an accident touch the one who gives the food. The most important thing is also to see that the child does not spill the food.

There is someone else, also waiting in the street, the dogs. The family members shall walk out with two separate plates, one to be emptied in the utensil and one on a big stone plate fixed at a place for the dogs. Sometimes the dog will smell the food and without touching it, walk away.

After waiting for some time on realisation that no more food shall be coming they will walk away to their house for dinner. Three kinds of food is given to them. Fresh but not consumed, fresh which is consumed but in form of leftovers in the plate, especially from the children who cannot finish everything on their plate, and the third kind of food being the leftover from the afternoon.

Children on either side learn simultaneously. How to give and what to give and how to receive. The only people who come to ask for food are from the community called *Bhangis* or scavengers. Sometime even beggars come and beg for food but they will name the food that they would like to have i.e. they will say, "Please give me some vegetable."

3.3 Baa, would you please pour water for me?

Baa Paani Redi Aljo

A woman of high caste is addressed as 'Baa'. *Dalits* are not allowed in many villages to draw water from the well. The worst is that scavengers are not allowed access to the well, meant for *Dalits.* They have to wait at the side, until a high caste lady has some mercy and pours some water in their pots.

Especially in the agriculture season, when the sowing operations are on, one has to wait for hours to get a pot of water.

3.4 A Kind of wild grass

Dabhdo

Dabhdo, the grass has multi utilities in villages, especially to save the family from the wrath of super natural elements. A little Dabhdo is always put along with the dead body in the grave. It is also required when there is a sun eclipse, which is believed to bring disaster to the family. The sun during the eclipse is believed to be possessed by 'Rahu', a demon. Therefore, to save the family from likely disaster, during the sun eclipse some Dabhdo is thrown on the roof of the house.

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A *Bhangi* always handles Dabhdo on such occasions. If at all the wrath comes it shall come to him.

3.5 Zampdo And Zampdi

Gods and Goddesses can be divided into two parts; of the upper castes and of the rural, lower caste poor, who mostly have their own local village goddess (called Gram-devta). These local gods-goddesses are not a part of the classical Brahminical Hindu religion, and can be appeased only by "black" magic rituals.

There are some who bring love, compassion and wealth. There are others who bring wrath and disaster and have to be feared. It is interesting to note that all good gods (who promote welfare) i.e. Saraswati (goddess of education), Lakshmi (goddess of wealth), Brahma (the creator) are worshipped by the high castes. They are painted as artistic and beautiful personalities, fair and attractive with compassion in their eyes.

Bad Gods (who bring destruction) i.e. Meldi (who ask for child sacrifice), Kalka (black with long tongue) are worshipped by the poor. Hadaksha (the goddess of rabbies) is worshipped by *Bhangis*. The Gods for the poor promote only destruction and fear.

Similarly it is believed that close contact with *Bhangi*, whether dead or alive is equally harmful. The ghost of a *Bhangi* male is known as Zampdo and the female one as Zampdi. All other ghosts can be appeased but not Zampdo and Zampdi.

Therefore one does not find a *Bhangi* roaming around after dark during the pre-Diwali festivals. They are scared that they shall be subjected as the victims of super natural elements. This is a good trick to keep *bhangis* away during the fun and frolic, which is the major attraction of these festivals.

3.6 Burial Cloth covering the dead body

Kafan And Loogdu

End of life journey is death. The dead body of a male is covered with white cloth and the female body with red cloth, known as kafan and loogdu. Just before the body is laid to the final rest in the grave the cloth is removed and hanged to a bushy shrub.

After the burial, the *Bhangi* takes home the Kafan for a new dress.

Part-IV: Prohibitions

4.1 Marriage procession cannot enter the village

Jaan Gaam Mathi Na Kadhay

The marriage procession of a *Bhangi* cannot enter the village from the main gate. Similarly they cannot decorate themselves with jewellery or good shining clothes. There have been serious incidents of attacks on the scavengers for not having obeyed the above rules. They cannot hire music parties on the occasions as done by others. A young boy was beaten up because he had put his shirt in.

4.2 Can we celebrate pre-marriage ceremony?

Phuleku Pheravvu Ke Nahin?

Phuleku is a pre wedding ceremony where the boy, with a flower garland around his neck, painted with termarine powder (believed to be skin purifier as well as skin shiner) and with a

knife and coconut in hand (knife to protect against the evils) is invited around to all the families of his community. He is fed with sweets and given some money as gift. Normally he is accompanied by his friends and young girls who shall be chanting marriage songs.

In higher caste communities the same ceremony has added elements. The boy is on a horseback, going around on public roads with musical instruments and firecrackers.

Dalits are not allowed to do anything by which their ceremony matches with the one of higher castes. There have been incidents of mass attack, where *dalits* had tried to sit on the horseback for the ceremony.

4.3 Which way shall we carry the dead?
Maaiyaat Kyan Thi Kadhshu?
There is always a cause for worry when someone dies in the community. The dead body of *Dalits* cannot be carried out to the cemetery by the main village gate, for it would defile the village. Often, therefore it's a long detour by the time the body reaches the final destination.

4.4 (And, we dropped ourselves from the School)
Ane Ame Bhanta Bhanta Utri Gaye
Sangeeta, now 14 years, describes how she was pushed to the last bench in the class by teachers. Earlier she scored very good marks. But she and other children felt psychologically so harassed by the teacher that they dropped out of the school.

"I had dreams that one day I shall be the Nurse or the Doctor... but I have become the scavenger. All my dreams have shattered." Unable to continue she breaks down in tears.

4.5 Can't you see? Have your eyes blasted off?
Bhadto Nathi? Ankho Phuti Gayee Chhe?
One hears this common phrase, whenever a scavenger community person approaches a higher caste person and thereby comes at a close distance. The connotation is for untouchability. The former has to stand or walk at such a distance that his shadow does not fall over the latter.

4.6 Who will make grain flour for us
Darav Vanu Dukh
In many villages the flourmills owned by high castes do not grind flour for scavengers. They have to go on cycle to other villages for the purpose. This is a major problem we have seen in the villages of Patdi taluka, in Surendranagar district.

4.7 You, get up from here
Ey Utho Ahinthi
In a village called Zanand, 70 km. Away from the state capital, the scavengers are in really difficult position. The village has no wasteland, as the village being close to the river and the land being fertile, all wastelands have been encroached. The problem for *Bhangis*: Where to go for toilet? Wherever they go, while they are in the middle of defecation process, someone or the other of the high caste will force them to get up and go away. This applies even to women.

4.8 Sit on the floor
Niche Bes
The *Bhangi* or other *Dalits*, though elected as the members in the local self-government, shall not be allowed to sit on the chair. They have to sit on the floor. There are times, when they are

not summoned for meetings. Later their signature or thumbprints are acquired as proof that they have attended the meeting.

4.9 Is mohan home?
Mohan *Gher Chhe?*
Mohanbhai is my colleague in his early forties. He belongs to the community. It was dark all over and we were waiting for the dinner to get ready. Someone shouted at the end of the street. On his return I inquired as to who was the caller and I learned that it was the village postman. The post is not delivered at home. Mohanbhai however being a worker is delivered the post at the end of the street.

4.10 Get the Ram's-god's cup
Ram Patar Utaril Laav
'Ram patar' is a name for cup made from soil, kept separately for *Dalits* in almost all upper caste houses. It is placed over the outer pillar, under the roof. So when any *Dalit* member goes to that particular house, they are offered tea in that After the tea, which is poured in the cup from above, he has to wash (again the water for the purpose shall be poured from above) it and place it at its original place.

"Ram' is the name of the lord, after whose name the cup is named. For *Dalits*, including scavengers, the very fact that they were offered tea, by a high caste person is an occasion of pride. In a village, there are times when the exploitation shall not be direct. The community leaders shall be used over a cup of tea to be mediators The leaders hold quite a clout over the community. In cases of borrowing money from the landlords, one has to go via these community leaders.

Part-V: Desperate search for subsidiary sources of income

5.1 Collecting bones from garbage
Hadka Vinvana.
Adults and children collect bones, are collected separately along with paper and glass pieces, to be sold for a petty sum in the market.

5.2 Supda And Indhoni
Supda means a straw made flat plate type article, used to clean the grain before cooking, whereby it will be separated from the small particles of hay and other waste material. Indhoni, is a grass made small round article which women place on their heads to support water pots.

For *Bhangis* the only 'clean' means of earning some petty income is to make two articles of household use from dried grass. These are known as **Supda** and **indhoni,** used by all castes. In the primitive barter economy of the village the *Bhangis* are paid in kind (grain) and not cash. Buyers are few and far between. The only significance is that these articles are not considered polluted by their touch, and that in a small way there are allowed to become **artisans** for a while.

Part-VI: Self-perception and as perceived by others

6.1 Destiny Inscribed by goddess Fate on the sixth day after the birth.
Chhathhi Na Lekh.
After the child is born, on the sixth day a ceremony is conducted. A piece of paper and pencil is kept under the pillow, over which the newborn baby is sleeping. It is believed that Goddess

Fate or 'Vidhata' insribes the fate of the newborn, which can never be undone. No wonder, most *Bhangis* believe their present fate to be divinely ordained.

6.2 Sir, we are like animals
Saheb, Ame Rahya Dhor
Whenever you enter a scavenger colony and start a dialogue, about getting organised or fight for rights, someone or the other shall say, "How can we understand all these. We are like animals."

6.3 Boys have names like waste, unclean, dusty, idiot etc.
Kachro, Melo, Dhudiyo and Bogho
These are common names found of persons in the community. One can add more to the list. In Gujarat, all male names carry 'Bhai' (brother) and females 'Ben' (sister) behind their names. But not for *Bhangi* and *Dalits*. Even the government records would describe their names as most insulting. The rest of the communities shall address *Dalits* in the same insulting tone. On the other hand an elderly *Dalit* person dare not address a feudal kid without respect. In cities now the generation is named better.

6.4 He is completely rotten, very sick.
Akho Ne Akho Haadi Gayo Chh
This is how a very sick person is described in the community. The phrase i.e. 'sadi javu' (rotten up) is used in the context of vegetables or fruits. A study conducted by a special team set up by the planning commission of India to study the health problems of scavengers say that scavengers are more vulnerable to anaemia, diarrhoea with vomiting, respiratory infections, skin diseases, jaundice and other ailments compared to others.

6.5 From where shall I start counting my sorrow?
Dukh Chyanthi Ganvoo?
Especially the old within *Bhangis* are seen in a pathetic condition. Crippled by age and negligence they are a helpless lot. One only hears from their mouth the repeated wish of an early death.

6.6 Will you have tea?
Cha Piso?
Even when the scavenger knows that you do not consider them low as others do, every time they shall make it sure by asking whether you will have tea or water at their house. Those who believe in untouchability as far as food is concerned, like many social workers we have seen (although they will sit in their house), shall deny politely, "no, thanks, we just had". Scavengers are shrewd enough, and they will ask such people, "If you want we can get tea made in the market for you".

In cases of major atrocities on *Dalits*, the police protection is provided. The police from high caste will not receive even water from *Dalits*. In such cases *Dalits* shall go to the high castes, with whom they had a dispute, and request to provide food and water to the police.

6.7 How about a *Bhangi* having sex with you?
Taane Bhangiya Raakhe?
This is the worst abuse one can direct to a non *Bhangi* woman. It is provocative enough to murder the abuser.

6.8 Oh, I see! You are going around with a newspaper!
Chhapu Laine Fare Chhe?
Few days before the high court struck down the system of manual scavenging in village Ranpur, Kishorbhai, a leader of the community was with a broom in his hands. Now, he bought a newspaper. This was the comment passed by the high caste merchants as he passed through the market area.

6.9 Brother of the *Bhangi... Bhangi* behaviour
Bhangiya Ni Bhaee ... Bhangiyaa Weda
Whenever some one from any other community except the *Bhangi* behaves in unpleasant manner, he and his behaviour shall be described in the above manner. This is the worst kind of humiliation attributed to a non *bhangi* person.

6.10 *Bhangis* have crossed their limit
Mara Haara Bhangda Phati Gaya Chhe
This is the remark full of contempt and full of intolerance made by high castes, which also carries a bad word. Whenever a scavenger is finely dressed, going to college has purchased a vehicle or done anything, which suggests that, his financial or social position has improved the remark follows. "Mara haara" means my brother-in-law, and 'Phati gaya' means, they have crossed boundary. In crude sense it means 'they have gone above their status'.

6.11 Scholarship for the 'children of persons engaged in <u>Filthy and Unhygienic</u> Occupations'
This is how the government has framed a scheme to financially assist the school going children, especially of *bhangis*. The teacher is in charge of applying, securing and finally disbursing the scholarships from the government. The duties and powers of the teacher are discretionary.
There have been several cases where we had to intervene and force the teacher to pay up the scholarship money to the parents, which was not done for four years.

6.12 Loans for Dhols and Nagaras (Drums)
The Government of Gujarat has a special scheme for *Bhangis*. Financial aid is given if they want to purchase Dhols and Nagaras. "Dhol' is a drum tied around the neck and played. ' Nagara' is the drum which is placed on the soil and beaten. This is in pursuance of the 'self-government program, with a taste of 'Entrepreneur Development'.

6.13 You do not have any experience of business
Tamne Dhandha No Anubhav Nathi
The Central government in early 1990s declared open 'National Scavengers Scheme' The aim was rehabilitation. Rehabilitation package consisted of part grant and part bank loan, to scavengers for anything else, but scavenging. One *Bhangi* youth applied for the scheme. The government authorities approved part grant and forwarded the application to the local bank for loan. The bankers told *Bhangis* "since you have no experience in business, we cannot give loan". The loan was desired for capital money to buy and sell dress material. The loan amount was Rs. 5000/- (US $ 120) "How can I have experience, unless I do it?" Was the argument of the pleading applicant.

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Part-VII: Some stories of experience

7.1 The Story of Chhaniya Ghaun

'Chhaniya' means something, which is immersed in the dung of an animal specifically in this case of a bullock, and 'Ghaun' in Gujarati language means wheat. In a village called Vataman, in Ahmedabad District, my friend and colleague showed me that in the thrashing season, the wheat crop is thrashed by the bullocks manually, through a process of crushing wheat crop with their feet by walking over it round and round until, the corns are separated from the hay.

In the process the bullocks eat lots of raw wheat and discard the same, indigestible because of overeating, in the state of diarrhoea, with the dung in form of dribbling slurry. There are live human beings waiting for the bullocks to discard the dung, then fill it in the bamboo baskets, bring home the stuff, mix it with lots of water, separate the wheat, which shall settle at the bottom of the vessel. The wheat is then dried in the open sun to be then taken to the flourmill and consumed. The wheat collected like this can take care of the family for two or three months.

The persons who do this, as I have seen so far belong only to one community, i.e. the *bhangis* or the scavengers. Lately, with increased use of Tractors and Trashers, Chhaniya Ghaun are not easily available.

7.2 The Story of Laxman

Laxman is eight years old. He is staying with his grandparents. His parents are away in search of labour. The village is Vejalka in Ahmedabad District. There is a small pan – cigarette shop in the village. The owner is a Patel, the high caste.

The shop is a popular place for poor children. From here they can entertain themselves by watching television, in a house. It was a bad day in Laxman's life. He was so much engrossed watching a film on the television that he put his hand on the pan shop. The owner asked him to remove his hand. Laxman was too engrossed to hear. The owner threw a handful of wet lime paste, used in the pan at Laxman, but it fell on his clothes. It is the second throw that went straight into the eyes of the boy.

The eye specialist is not hopeful to save his one eye. I remember that day two months back, when Laxman came to my office with his grand father. He forgot his pain, as he concentrated on the refrigerator, closing and opening the same, wondering at the coolness. He asked me many questions about the refrigerator.

It was time I took him to an English newspaper's office. He, on climbing the vehicle, told the grandfather, "Papa, how nice this car is. Aren't we sitting for the first time." All along the road in the city, the evening life flooded with lights kept him amazed with open mouth. I asked him whether he would go to school now. He said, "If I go now, the student and teacher would tease me by calling be blind so I will go only after I am well."

7.3 I did not get the better part

Haaro Maal Mara Bhag Na Ayo

The place is a village in the Vadhwan taluka of Surendranagar District in Gujarat. The reference is regarding the injustice meted out to a person, the complainant being a person from *Bhangi* community over distribution of meat from a dead animal. When an animal is dead in the village, a team of at least four people are required to be able to drag the corpse of the animal

to an assigned place or where the assigned place is at a far distance, it is dragged to a secluded corner off the road.

The first stage is skinning which requires skill, as the well-discarded skin would fetch a better price in the market than the one, which shall be with punctures. The second stage is to separate meat according to the quality, as certain parts are considered better than the other parts. The third stage is distribution of meat, where survival of the fittest applies.

The quarrel was that the scavenger did not get a better part as the same part was cornered by another member who belonged to a higher caste, although a *dalit* himself. And as the matter could not be resolved amicably, it resulted into a police complaint. The police was more than puzzled not quite sure as to how to handle the matter and sought the help from our organisation i.e. Navsarjan.

Two of our colleagues reached the village to find that the aggrieved party had gathered outside the house of a retired police officer from the same village, who belonged to a non-*Dalit* high caste. It is a usual practice to beg for counselling from the higher castes in resolving inter-community matters. Definitely they were all standing outside the house making representation.

When the retired police officer came to know that two workers of the organisation had arrived he invited them in the house. One dare not observe untouchability with the workers. One of the two workers was from the same community, a *Bhangi*. Suddenly there was hue and cry as the host offered drinking water to the workers, from the people standing outside saying, "Sir, He is our *Bhangi*, a lower caste, he cannot drink water from your house." There was so much heat in the environment that as the workers observed, the aggrieved party had forgotten completely about their original grievance.

The issue to save the master from any defilement that might come to him from the action of their community member by drinking water from the former's house had taken the precedence.

The story itself is nauseating. But in the area where 60% population has to migrate for more than six months a year in search of labour, the poorest have no option but to eat what is available.

The incident of 1920s flashes through the mind, when Gandhiji gave a call to *Dalits* to give up eating the dead animals, a factor he thought distanced them from others. He received two letters in response. The first letter was from a teacher of rural Calcutta. He wrote that when he gave up eating the dead animal, the same was thrusted in his mouth by caste Hindus, saying that it was his religion to eat it.The second letter was from a businessman from Bombay. He apprehended that if *Dalits* gave up eating dead animals, go for education, and thereby enter the business, what will the caste Hindus do?

7.4 The Story of Young Girls

It was a wedding time in the *Bhangi* colony, when few youths from the Darbar community, fully drunk entered and started making gestures at young girls. The host went to the Darbar elders to request their youth not to harass them, especially when there were many guests.

Everyone thought the matter had resolved until the same youth returned at midnight. On request from a very elderly person and his wife to have mercy they both were beaten up. These kinds of incidents were not new to the community in the village. A year back one of the girl was taken

away along with the cot on which she was fast asleep by feudals. She was returned almost after two days, saying she had lost her way and they had found her.

7.5 Unemployed *Bhangi* Primary Teachers

The hope for a prompt job has pushed many *Bhangi* parents to invest everything they have to enable children to study at the teachers' training college. In 1992, Navsarjan organised a protest programme in the former state capital. The day was 15th August, the Independence Day. The demand was for a change in the existing reservation policy; the main factor responsible for rendering over 1000 *bhangi* trained teachers unemployed.

This policy reserved 2% seats for the admission at the teachers college. This was done with acceptance that due to all kinds of hardships the *Bhangi* students couldn't secure more percentage in the matriculation exams. But when it came to jobs, it was on the basis of merit. Merit was drawn from the combined marks of both, matriculation and college. In the process most *Bhangi* students never stood a chance as they had lower percentage in matriculation compared to others. Our demand to reserve 2% of jobs to balance the position was accepted but never implemented. The entire reservation policy has changed now.

The changed policy has made it compulsory for schools to advertise for all vacant posts. The schools are given liberty however, to turn the 'reserved post' as the 'unreserved post', if they do not find a suitable candidate after three rounds of advertisements and personal interviews. The *Bhangis* or *Dalits* never prove to be 'suitable' in schools managed by caste Hindus and their organisations. One job however is reserved 100% for *Bhangis*, the scavenging.

To conclude, it is not enough to develop beautiful plans for the rehabilitation of scavengers. The most question is whether the state in power recognised them as human beings.

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Paper: 12

Gender violence: Caring for survivors

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Gender violence usually refers to the violence towards women in the form of rape, abuse, and molestation, either outside the house or within the house. A large number of statistics are available about different types of violence being practised towards women. However a very little data is available about the measures taken to stop the same. This itself reinforces the violent act and perpetuates violence. Role of media, health professionals, political and spiritual leaders in controlling gender violence have often been over emphasised. However, very rarely their contribution in violence towards women have been talked or written about. This paper highlights the various ways in which violence is silently practised and ignorantly perpetuated by the media, health professionals, political and spiritual leaders, and family members. An attempt is also made to suggest an action plan that can be implemented effectively.

Media: Media prints the act of abuse or rape or molestation or dowry death as headlines. However, very rarely a measure taken by either police or judiciary court is acknowledged as headlines. It generally gets printed as a small column on the third or fourth page. The psychological message given to the masses is that the violent act is the priority of media. On one-side media stands strong for a brave girl like Jayabala, the other side often the media withdraws from a sexual violence towards a woman by a significant person of the society.

Health professionals: It is taken for granted that health professionals are always associated with the "Damage control – Gender violence" group. This is not true. Often a health educator, a sexologist, a teacher engaged in the sexual harassment of his student or a colleague gets protection from his other senior colleagues and thus helps him in perpetuating the violence towards women. A professor of a very well known college of Bombay who had established himself as "Honest" and "Gandhian", wearing "Khadi" life time is actively engaged in sexual malpractice under the pretence of WORSHIPPING the students and colleagues. He bribes his students by offering then incentives like passing in the examinations or by blackmailing students emotionally or threatening to spoil the professional record of a colleague.

Political and Spiritual leaders: Political and spiritual leaders have a very strong influence on the youth. They also have power associated with their positions. Most of these authorities have good intentions of using their power and influence for the welfare of the society. However, it is come to the notice of many people that some political leaders are themselves engaged in violence towards their own wife as well as daughters demonstrated by visiting a Traditional Folk Dance and producing a male child despite having adequate numbers of daughters just to prove their masculinity. They are further involved in the emotional violence of a child by disowning him publicly. Spiritual leaders sometimes knowingly and more often allow unknowingly the unhealthy sexual behaviours in the ASHRAMS where one is supposed to be engaging in spiritual learning.

Domestic violence: Domestic violence is also very lavishly practised and nurtured over generations together. Single women and women having infertility problem are usually the most severely affected by the domestic violence by either mother, mother-in-law or close relations. Single women's modesty is often violated by words, emotions, and character assassination by her own close people. Most married women do not respect single women's personhood. At

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work also, most single women experience a significant emotional violence by the colleagues and the relatives of the colleagues. Infertile marriage be it male factor or female factor, the consequences are often faced by the women in terms of social and emotional rejection not only by the in-laws but also by husband. If there is no male child born after two daughters then only wife is held responsible for it and husband goes out of the marriage to produce a male child. However, this is not true for all the married couples.

Why there is so much violence?

Most of the time a stereotype reason "It is male dominating society" is given at the end of any lay person or a scientific conversation. Sometimes the responsibility for change is transferred on males to make them feel important. However, it very important to know that the maximum responsibility of correction lies on the survivor of a violent act and not on the person practising it. Most women do not want to take responsibility for their self-esteem. They have no self-concept. They believe that their parents are responsible for bringing happiness in their life by educating them and getting them married to the appropriate person. After marriage, they consider their husband to be responsible for their happiness by entertaining them sexually and giving them children and motherhood. Once husband is lost they feel it is their children whom they have given education and property are responsible for the welfare of their life. In the old age, if these women are spiritually inclined then they hold their spiritual master responsible for their well being. All throughout the life cycle, women rarely own up any phase of her life and this is the most important factor making her vulnerable for all forms of violence throughout the life.

Action Plan to stop the violence against women

- Self-awareness program for women
- Female Sexuality self-help group counselling
- Financially independent but not arrogant
- Socially and emotionally stronger.
- Relating to complimentary sex and not to opposite sex
- Growing in love and compassion rather than competitive with the men
- Enjoying being a woman
- Developing gender sensitivity rather than gender equality.
- Modelling for qualities
- Inviting more participation by male in the " Damage control" program

It may sound very theoretical but just the way "Charity begins at Home" let "caring Begin at Home."

CEHAT, Mumbai, India

Paper: 13

Jail situation in bangladesh
An epidemiological over-view of the prison health

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Introduction

Bangladesh is the vast field of distorted humanity & violation of civil rights for the last long period. Violence is the common form of procedure practised widely by the social terrorists, armed political cadres, woman and child traffickers cum abusers, religious fundamentalists & even the state machinery. Generally the innocent people, women, children, labourers, students, prisoners & detainees are the victims. The condition of the Jails of the country are extremely humiliating leading to gross violation of human rights inside.

Territorial background

Bangladesh is having a thick population (830 persons per sq. km.), poor economy (per capita income: US $ 210 &GDP US $ 227), low literacy rate (32.4%), scanty natural resources (mainly gas), primitive industrialisation and deep seated generalised corruption & administrative mismanagement cum social injustices. In continuation of the long British & Pakistani colonial rule it's post-independence 25 years of national life was mostly imposed with direct or indirect army rule where lack of democracy & accountability was the real essence of the state. Eventually this situation led the nation to such a position that the law & order enforcing agencies & establishments became incredible torturer during the last long autocratic regimes.

Jails in Bangladesh: Impressions in general

The Jail is one of the important venues for the violation of human rights by the police as well as the backdated traditional prison management procedures. Generalised impression about the prisons in Bangladesh among it's citizens is that, these are the places of extreme discomfort, sufferings, distress and torture; jails are nothing but hell. From a professional point of view the prison health is one of the major concerns in Bangladesh health delivery system which needs to be attended to, for its epidemiological significance. It also implies an optimum, realistic & factual understanding of state violence dimension in the country.

3.1 Jails in Bangladesh: Basic information

Table: A

Total number of Jails	77
Number of central Jails	04
Number of District Jails	30
Number of sub - jails	27
Number of Thana Jails	16
Total capacity	21,620 Persons

Other auxiliaries:	
Thana police custody	490
District court custody	64
Safe custody	Variable

Law & order situation: Backup contributor for the jails

As we know, the over all law & order situation is the key - factor to determine the inflow of the prisons and custodies following police & other agency actions, so we may have a gross view over the law & order violation incidences in Bangladesh in the following table.

Table: B

Incidences	**1995**	**1996**	**1997**	**1998 (upto July)**
Rapes	216	249	507	459
Murders	2190	2690	2911	874
Suicides	884	2506	-	347
Terrorist acts in educational institutes	272	162	-	41
Killings in edn. Institutes	47	09	-	-
Women's death of dowry	45	103	-	68
Acid burnt	181	89	-	88
Whipping on women	22	-	-	-
Dacoity & robbery	1965	3281	-	864
Total number of acts	**13,791**	**13,970**	-	**4,282**
Total arrests	-	38,691	-	10,640
Average number of arrests per incidence	-	**2.76**	-	**2.48**

3.3 This data is mostly based on press exposures & cases filed mainly by the urban oriented people. Vast rural & poor areas are devoid of optimum awareness, facilities & courage to enjoy the citizens rights of exercising contemporary legal ways. More over, case filing is generally discouraged or filed improperly by the police authorities. Therefore the number revealed here is absolutely few, remotest & far away from the actual huge number of unknown violence going on in every day life, which is presumed to be around one hundred thousands in a year on an average. However as my concern today is limited within the people undergoing arrests & convictions only, I would like to indicate here only the depth & extent of socio-political violence in Bangladesh.

Jails in Bangladesh: Living conditions.

So far the socio-political conditions prevailing in Bangladesh, the initiative for the Jail study by any individual or organisation is not readily encouraging However a study on the in-side environment was carried out with multiple formal & informal professional approaches to different categories of jails (19) during the period from 1995 to 1997, in addition to some of the press reports for the following statistical compilation.

Table: C

Jails	Category	Capacity	Occupancy	Staff	Toilets	Hospital
* Natore (1996)	Sub - jail	94	440	21	8	Nil .
*Chuadanga (1997)	Sub - jail	39	327	24	-	Nil .
*Satkhira (1997)	Sub - jail	80	800	-	-	Nil .
*Magura (1996)	Sub - jail	42	300	-	-	Nil .
*Nilfamari (1997)	Sub - jail	94	205	-	-	Nil .
*Gaibandha (1997)	Sub - jail	114	230	-	-	Nil .
*Serajgonj (1997)	Sub - jail	165	442	-	-	Nil .
*Sunamgonj (1996)	District Jail	104	534	47	11	Nil .
*Narsingdi (1996)	District Jail	85	400	28	8	Nil .
*Narayangonj (1997)	District Jail	126	811	25	7	Nil .
*Kishoregonj (1997)	District Jail	201	800	39	12	Nil .
*Jessore (1996)	District Jail	1400	2700	-	-	yes .
*Dinajpur (1996)	District Jail	300	800	-	-	Nil .
*Cox's Bazar (1997)	District Jail	140	910	-	-	Nil .
*Gazipur (1997)	District Jail	70	325	-	-	Nil .
*Jamalpur (1997)	District Jail	177	500	-	-	Nil .
*Noakhali (1997)	District Jail	348	718	-	-	Nil .
*Dhaka Chief Metropolitan Magistrate court Jail (1997)	Court custody	50	400	-	1	Nil .
*Dhaka central Jail (DCJ) (1997)	Central Jail	2116	6000	700	few	Yes (100 beds)

4.1.0 Now we can proceed to consider the information gathered on the overall facilities & service delivery status of the Jails, which are as following:

4.1.1 Accommodation for the inmates are absolutely inadequate, in comparison to the existing provision in jail code of 36 sq. ft. space per person . We can assume that sub-Jails congestion is more than 5 times, while that in District & central Jails is around 3 times. However a different conservative source of reporting reveals the following situation of congestion:

Table: D

Category	**Total Capacity**	**Total occupancy**	**Congestion**
26 Sub jails	2,765	8,361	3.02
32 District Jails	12,347	23,948	1.93
4 Central Jails	6,328	14,477	2.28
Grand total in 77Jails	**21,620**	**46,786**	**2.16**

4.1.2 The tight accommodation is nothing but a good tool for punishment of someone or all, as well as for procuring financial benefit for the management staff. Everywhere all the in- mates can not sleep at a time, many have to remain awake or sleep on sitting posture while few are in sleep. They can avail a back to back space for sleep only on rotation basis. One person uses another's trunk as pillow.

4.1.3 Lack of proper ventilation, minimum air flow through the windows, absence of any electric fans & inadequate light is a common scenario in all the Jails. In some Jails high powered (400 watts) electric bulb shines over night non-stop. It makes the room hot & induces profuse sweating among the inmates.

4.1.4 Adequate water supply for bath & other purposes and safe drinking water is not available readily or at all in the Jails. A long queue for the use of bath-venues is the common picture everywhere. In DCJ one prisoner can take bath only once a week, on rotation basis.

4.1.5 Toilet facility is also inadequate, dirty, full of foul smell, over flown or dried up every where. Again a queue is common feature during peak use-hours.

4.1.6 Kitchens are small, poorly arranged & deliberately mismanaged to provide inadequate, sub-standard food for the inmates in all the Jails.

4.1.7 Dietary standard is one of the major concerns in Bangladesh Jails. Food is partially consumed by the sentries, supplied with small pieces of grabbles, sometimes even with insects. Fresh food is unimaginable particularly in big Jails. In DCJ food prepared today is distributed to the consumers at least after 24 hours, food is not edible in any Jails. Diet is undoubtedly sub-standard in terms of quality, amount & food - values. Food items in Central Jails include bread, molasses, pulse, vegetables. To understand little more we can pick up the diet menu of a district Jail, which is as below :

Break fast: Bread & molasses (580 - 700 grams)
Lunch: Hand made chapati : 2, some vegetables.
Dinner: Rice, vegetables
Fish or meat once a week.

The source said that the quality food supplied daily is not readily consumable by the prisoners They eat just to survive

4.1.8 None of the Jails have any recreational arrangements like games, sports, cultural programs, studies of books, religious activities or corrective vocational training. Rather some local type of casino is existent inside as part of the moral degradation process.

4.2.0 Disease profile is also very much identical in all the Jails of Bangladesh, which could be identified as following :

4.2.1 Malnutrition & deficiency diseases eg anaemia, glossitis, stomatitis etc. are very much common. Female prisoners & their babies are the major victims. Some of the female prisoners have their children dissociated from the mother & staying at home - they are also deprived from breast feeding & proper diet. Some of the in-mates' babies are suffering from Kwashiorkor & marasmus.

Skin & venereal diseases arising from congestive accommodation, intermixing of sick people with the healthy ones, unhygienic environment, clothes, belongings & homosexuality. There is no provision or arrangements for periodic sexual meets of the prisoners with their spouses. Common skin & VDS encountered in Jails are scabies, fungal infestations, infected sores, dermatitis, eczematous lesions, pityriasis versicolor
infestation, gonococcal & syphilitic infections etc.

4.2.3 Genito-urinary infective disorders like non - specific urethritis, cervicitis, vaginitis, & leucorrhoea are also reported to be common.

4.2.4 Gastro-intestinal diseases like helminthiasis, amoebic & bacillary dysentery, chronic peptic ulcer, non - ulcerative dyspepsia, diarrhoea, typhoid, irritable bowel syndrome (IBS), haemorrhoids are generalised among the inmates.

4.2.5 Mosquito is one of the important vectors in Bangladesh - prisoners are not provided with mosquito nets. So malaria, dengue & filariasis are common among them.

4.2.6 Low ventilation & suffocative environment, tobacco smokes, exposures to much cold or heat are initiating allergic rhinitis, bronchospasm among some of the inhabitants.

4.2.7 Inadequate monitoring & lack of proper medications, physical & mental strain are quite provocative for both the potential & established hypertensive prisoners.

4.2.8 Persons having pre-existent diabetes mellitus & cardiological disorders are always prone to be deteriorated or complicated due to lack of more mobility, proper exercise, relaxation & optimum sleep. Sudden 'unexplained' deaths are not uncommon in Jails. Particularly these sorts of problems are prevailing among the prisoners in Jails out side Dhaka or where no prison cell is available, no nearby hospital & there is no inside hospital or medical centres. Many cases are referred to these hospitals in dying condition & death is their almost invariable fate.

4.2.9 Huge numbers of prisoners in every Jail are drug addicts in varying degrees, common drugs & liquors available are alcohol, cannabis, pethidine, heroin (brown sugar), phensidyl, opium & of course very widely the tobacco preparations, though all are absolutely prohibited except the last one. Unscrupulous drug trafficking groups are assumed to be interlinked, in some way, with the inmate consumers. Some of the crazy addicts inside the Jails were reported to be so extremely desperate in some rare situations when drugs were not available temporarily for some reasons, that they would draw their own blood with syringe - needles & enjoy after mixing with cigarettes through smoking; Or catch some cockroaches & swallow them with cold

water. The extent of deterioration in psycho - somatic status of these people could be noted to understand the environment inside the state - owned prisons!

Extreme physical & psychological strain is the very inevitable outcome of such situation in the Jails of Bangladesh. Big number of prisoners gradually become trapped into stress - disorders & the following psycho - somatic manifestations are noted to be pre - dominant among them even after their release from the Jails.These are: Headache, anxiety, depression, poor sleep, fatigue, easy frightening, weakness, irritability, hallucinations , sexual disturbances, suicidal tendency, introversion, lack of initiation, violent attitude, drug addiction, reduced work-ability etc.

4.3 Now, If we look back to our Table -C , we can well assume that the most neglected or over looked component of the Bangladesh prison management is the health care system. Very few of the Jails have their own hospitals or medical centres. A total number of 19 jail hospitals comprising only 1003 beds are known to be existent all over Bangladesh for more than 46,000 inmates. Most of the Jails don't have resident doctors, nurses pharmacists or allied professionals. Doctors are called in whenever necessary from outside. Patients are some times referred to local hospital's out patient departments for clinical treatments.

We can have a precise view over the best possible health care arrangement in DCJ which is a 100 beds hospital with only three doctors, no professional nurses & no modern instruments. Hospital occupancy is always double the capacity where the number of genuine patients are very few - rather most of then are 'fake' patients, at the cost of BDT 3000 - BDT 5000 (i.e. US 61 - US $ 100), which is alleged to be taken by the Doctors. Actually the principal criteria for admission into the Jails hospital is not the severity of the disease but the amount of money. Doctors can issue 'health cards' for the non - admitted 'patients' which will ensure the 'patient' with one week supply of Banana, green coconut, egg & milk. But again it will cost about BDT 500 (i.e. about US $ 10). There is no separate arrangement for female patients. One female doctor from outside visits the sick woman prisoners twice a week. Doctors can refer any patient to any out side hospital for better management - patients have to absorb the agony of these referral procedures as well as the ongoing low quality health delivery system in the hospitals of the country. Only two general hospitals in Dhaka city have got 'prison cells' to provide care to such patients. But only the well - off prisoners can avail of this facility easily.

4.4.0 Violence over the prisoners & detainees deserves a special consideration to understand the etiological aspects of prison health - calamities in Bangladesh. At this stage we can have a view of the state-sponsored violence as a whole, done by the police & other state forces from in the following table.

Table: E: Acts of police & other state forces:

Acts	1995	1996	1997	1998 (up to July)
* Death in custody	101	19	03	04
* Death in Jails	-	29	23	26
*Killing by police & others	-	43	28	18
*Injuries by police (bullet)	83	60	174	11
*Rapes by law enforcing agencies	17	11	11	05
*Torture by law enforcing agencies	-	-	-	449

4.4.1 State sanctioned tortures are going on every day mainly by the police inside the Jails, Thana police custodies, & custodies of police intelligence agencies. The most open secret matter in Bangladesh is that all the arrests, interrogations & approaches by police are invariably equipped with some sort of torture appliances or methods. Every year multiple stories of inhumane & cruel stories of torture are coming to the press following the death incidences in the custodies.

4.4.2 Jail Administration: the worst police authority of violence.

They are the best beneficiary of the worst & inhumane situation prevailing inside the Jails. They have maintained status quo for several eras. The gloomy pictures of tight accommodation, poor diet, scanty water supply, ill-ventilation, unhygienic environment, dirty toilets, drug abuse, lack of health care facilities etc. are exploited & earned substantial amounts of money both from the prisoners well as the public fund. Only money can ensure a relative comfortable space for sleep at night, good food, adequate water for bath & drinks, meeting with the relatives, hospital facilities inside & out side the Jails, medications, special diets. If someone intends to protest, he/she has to face the tortures of varying degrees.

Punishments include- abuse, slaps, blows, beating with sticks, kicks, whippings, water-suffocation, excess lights on eyes, application of iron bars (eg. Link-fetters, bar-fetters, cross-bar fetters, hand-cuffs) & confinement without food. So far four persons to have been allegedly killed by the police inside jails & custodies during the first seven months of 1998.

Actually the lawlessness, cruelty, corruption, mismanagement, injustice, etc are the common components of the jail administration in Bangladesh.

4.5 "Safe custody" - the imprisonment in disguise.

In Bangladesh the woman & children who were rescued form the illicit traffickers, or the women who are plaintiffs but remaining under the threat of social insecurities, victims of disputed marriages, raped, arrested on doubt are kept in 'safe custody' by the judiciary. There is no such provision in law & jail code but is commonly practised by the court. There is no separate place for the persons who are kept in 'safe custody' - just they are put in to the jails to face the whole intolerable agony, thought they are not accused or convicts.

So far the information gathered, up to April/97, there were 269 persons 'enjoying' the safe custody systems in 54 Jails, of which 226 were women. Some of them were detained for last 14 years, they are deprived even from the visits by the relatives (because it needs permission from the court - but they can't afford the procedures), some times they are the worst sufferers of negligence. There are many tragic incidences of unavoidable misery & misfortunes encountered by the victims of ' safe custody' in Bangladesh & it is one of the significant epidemiological contributors to the prison - health situation in Bangladesh.

5.0 Jail Revolts:

In protest to the situations prevailing inside the jails, the revolts of the prisoners are also no less frequent in Bangladesh. The country observed these mutinies in1976, 1977, 1980, 1990, 1991 & lastly in December, 1996 where police crushed the initiatives leaving 10 prisoners shot-dead, 400 injured. Jail revolts took at least 70 lives after the liberation of the country in 1971 Apart from revolts, prisoners try their best to escape from different Jails off & on.

The causative factors behind these revolts & escapes are chiefly the repressive environment due to the existence of conflicting laws & non-issuance of new necessary laws in due time.

6.0 Jail Reform :

The appalling condition inside the Bangladesh prisons are impressively sufficient to understand that no reform, change, or development has been done so far for its improvement. However a Jail reform commission was constituted in 1978 being headed by a Justice. The commission submitted an extensive report in 1980 based on its study of the prevailing situation of Jails at home & also 17 other countries of the world. It suggested about 500 reform components for fundamental & extensive changes in the Jails of Bangladesh. But in last 18 years only 37 of them were implemented, so far.

7.0 **Now at the end following are my conclusive inferences which can be drawn from the observational studies in Jails & custodies of Bangladesh :**

The approach of the prison management in Bangladesh is still punitive & exploitative but not corrective.

The overall attitude of the Jail authorities was designed to damage the personality, health & future life of a prisoner.

In particular the living condition, environment, administration & health care systems in the Jails all together are the meticulous etiological contributor to the worst prison health condition.

For the better & the greater sake of public health as well as democracy & civil rights, prisons in Bangladesh, need not only a fundamental reform but also a 'cultural revolution' inside.

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Paper: 14

Who cares for torture victims
The West Bengal experience

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Torture

Torture, as a phenomenon is not new. In Bengal (and similar examples can be found elsewhere, too), the colonial police system owed its origins to the state's need to systematise rent collection rather than in its law keeping responsibilities in the modern ethical sense. Coercion was congenital with this system.

This coercive machinery, empowered by a series of repressive legislations, came in handy for the colonial rulers for suppressing the national liberation movement. Torture had become the order of the day by the beginning of the 20th century. Among its multiple uses, the extortion if confession, replaced extortion of rent as the major one.

Confession is an important theme in the theolegal jurisprudence of the Western tradition (down to the point of, if we are allowed a little digression, l'affair Clinton) that was globalised by imperialism. It is also a convenient tool of summary justice, which the state uses produce quick results, as a sort of magic remedy for both its own woes and those of the people. Thus it also became established as a method of crime "investigations."

The post-colonial state has been conveniently using the coercive apparatus imperialism had set up. The infliction of pain, physical and mental, apart from making one confess, can break the victim down to submission, collaboration or obliteration. Torture not only scares, it kills. The victim may be anybody whom the state and its agents want to break down a revolutionary, a criminal or simply one who has to be brought over.

Torture may be practised by anybody from a position of power on anybody who is powerless in a given situation. In fact, we have instances around us of torture by the more powerful members of the family, in majority if the cases male, by criminals, by landlords and their henchmen, by mobs acting in the name of justice and even by rebels professing egalitarianism. But we have reasons to be particularly concerned about the torture sponsored and sanctioned by the state.

The state is the most powerful sociological entity in the power structure need by torture to be operative and exploits this advantageous position to the maximum level. An individual, who us the ultimate target of torture, is not as helpless before any other agency as before the state. The sanction of the state is the ultimate sociolegal sanction and is given in the name of the whole body of citizens that it claims to represent. Agencies such as the police and the armed forces acting on its behalf are considered to have this sanction automatically. When this sanction is for torture, a practice that dehumanises human beings gets the General Stamp of Approval.

The "spectacle of suffering." to borrow Michel Foucault's description, has become an integral, though unacknowledged, part of statecraft. No government, colonial or post-colonial, has been

able to do without it. In West Bengal (and earlier in undivided Bengal) we have seen this practice continuing under the widest variety if political rulers: colonialists, nationalists, as well as leftists. Here we shall take a close look at our recent experience.

Intervention

Torture by the state agencies is thus a major issue for any initiative concerning human rights. In most cases, intervention in this type of violation of human rights involves two processes. First, the incident is highlighted by the activists and the media, sometimes by the media before the activists and sometimes the other way round. The chances and the extent of redressal depend upon the strength of the consequent public action.

In the 1990s, public litigation by torture victims and their family members, often assisted by human rights groups, have become more frequent than in the past. The West Bengal Human Rights Commission receives many petitions in this respect and recommends actions against the guilty policeman. In spite of its legal operational limitations, the commission has been able to at least make many policeman think twice before getting into the act. The latter, interestingly the 'elite' officers in particular, can be heard lamenting regularly in the media about the police being rendered "toothless" against criminals by the human rights "bogy" And to boost their "morals" at "crime conferences', police minister Buddhadeb Bhattacharjee has to deliver sermons such as "Be ruthless with the criminals. You don't have to worry about the Human Rights Commission, we will take care of them."

Some redressal is being offered by the state to the victims or their kin, usually in the form of monetary compensation and legal procedure against the perpetrators of the crime.

Some instances:

The SHRC has ordered an investigation into the murder of Sajal Goswami, a law student and CPI (ML) activist, in Malda district in September 1996. This is the first time the commission is going for an independent probe even after filing of charges by the police, according to whom, Goswami was lynched by a mob. The commission has found reasons to suspect that he was tortured and killed in police custody.

Meanwhile, the victim's family assisted by the Association for Protection of Democratic rights (APDR) filed a case at the Calcutta High Court, which has also commissioned an inquiry by the district judge.

Sheikh Nazrul, a boy of Burdhaman district, was taken in custody to the Khandaghosh police station on 10 April 1997 on charges of theft. In the diary however, the date of arrest was noted as 12 April. He was later admitted to the local primary health centre and subsequently to the Burdhaman Medical College with injuries that he complained has been caused by beatings by the officer in charge and a few other officers. He had been severely kicked on his chest, back, and stomach.

The SHRC investigated the complaint and following corroboration of the doctor concerned at the medical college hospital about the nature of his injuries; recommended the recording of the charges in the policemen' service books, not to give the OC the charge of any police station for three years, and payment of Rs.15, 000 to the victim's family, which if the government decides, may be realised from the policemen.

Pramatha Kayal of village Rameswar in South 24-Parganas district was detained under more apparent charges at the Kulpi police station for about two weeks before he was produced in court on 24 January from where he for bail, incustody, he was denied food and physically tortured.

His family members lodged complaints against this treatment with both the subdivisional judicial magistrate's court at Diamond Harbour ad the SHRC. A probe by the latter revealed that the OC of Kulpi had been demanding Rs.20, 000 from the victim's family, which it could not pay up. The commission has recommended a CID enquiry, criminal prosecution of two police officers and leaving them without charge of any police station or circle for three years and a compensation of Rs.20, 000 to the victim.

Mohammed Alam, a contractor's labourer at the Garden Reach Shipbuilders and Engineers, Calcutta, was arrested on 29 march, 1995. He was found dead at the Garden Reach police station on 10 April. His mother, Jabeda Khatun, has been fighting a case with the APDR's help against the police for torturing her son to death.

Abdul Karim Farazi, a villager of Karimpur, Nadia district, was picked up on charges of dactoity, beaten and dragged to death tied behind a police jeep in 1995. His family filed a case at the district court. An interim compensation of Rs.50, 000 was awarded to Farazi's family.

The officer in charge was initially suspended following public uproar, but while the case was pending, his suspension was withdrawn and he was posted in Kalyani police station in the same district. Here he was accused of killing an alleged dacoit, Khagen Majhi, on a false encounter. Majhi's mother testified that her son was called out of the house and shot before her eyes. The APDR filed a case in April 1997 on this incident.

Raju Chakrabarty of Ranaghat, Nadia, a poor boy of 16, was detained on 25 December 1993, by the night watchman of the local market where he was roaming around with a loaf of bread in hand. The guard beat him up accusing him of having stolen the bread and handed him over to police. Unable to bear the thrashing at he police station, he died the next day.

The boy's father filed a case with APDR support at Ranaghat court. The sessions judge, Nadia, accepted prima facie the complaint against the police on 19 August 1995 and ordered a CBI Investigation. The state has, however, gone in for appeal and the case is still pending.

Sheikh Azad, alleged to be a criminal of the Calcutta port area, was arrested on 28 December, 1994, along with two others and severely beaten at the Calcutta Police central lock-up. He was removed to hospital and died on 10 April, 1995.

His newly married wife, Ruksana Begum, challenged the police version that he died due to tuberculosis and its current engaged a legal battle.

Dulal Ghoral died at the Panskura police station, Midnapore district, in September 1995, where he had been taken for interrogation in connection with a criminal case. The Lawyers Forum for Human Rights (LFHR) filed a writ at the Calcutta court.

In January 1997, a Division Bench held that the police had not only beaten the victim to death but also manipulated records to extricate themselves. The court ordered the officer in charge to be prosecuted and a compensation of Rs.25, 000 to be paid.

CEHAT, Mumbai, India

Debu Pramanik was detained at the Chinsura police station in Hooghly district illegally for 60 hours before being produced in court on 12 July, 1996, on charges of bootlegging. Bearing severe injuries from the beatings in custody, he was released on bail, but succumbed on the way home.

The Hooghly branch of the APDR filed a petition before the SHRC on 16 July, 1996. The commission, after investigating, found that severe torture had resulted in Pramanik's death. It awarded a compensation of 20,000 to his family and recommended the prosecution of the officer in charge, which the government accepted.

Subhas Das, another alleged bootlegger, was taken to Bhawanipore police station, Calcutta, in 1995, where he was reportedly beaten to death. The LFDR, assisted by the APDR, filed a case at he Calcutta High Court. The case created two important precedents.

First, the High Court entrusted not any investigating agency but the district and sessions judge, Alipore, with an enquiry, the judge, in his report submitted before the High Court in February 1997, upheld the contentions of the human rights bodies.

Second, the High court, in awarding compensation, showed rare ingenuity. Das had a wife, but for quite some time had been living with another woman. Despite the fact that the woman happened to be a sex worker, the court divided the compensation between her and Das's wife: Rs.20, 000 to the former and Rs. 80,000 to the latter. Criminal proceedings were initiated against the officer in charge concerned, who, however, has gone in for appeal.

Care

There is seldom any follow-up on the subject or the victim of torture. But human rights activism cannot concentrate on the 'rights' component without taking into view the human being, the possessor of these rights.

The Centre for Care of Torture Victim was formed in Calcutta by a group of doctors and activists in November 1997 with the following broad objectives:

Identification, treatment and rehabilitation of victims of torture(though the focus is on state-inflicted torture, the organisation has included in its purview torture by domestic, political and other agencies as well, because it believes that the practice cannot be justified under any circumstances in the interest of a humane society)

Developing awareness among the people, professionals and administrators on the problem of torture and is prevention;

Capacity building and research on medical and paramedical of torture victims; and

Considering an expressing views on all questions and laws pertaining to torture and torture victims.

The problem is a vast and complex one and the resources of the organisation, both human and material, are much limited. With the active co-operation of several other human rights, medical and voluntary organisations, the CCTV has taken up more than 20 cases in the past one year.

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Working with these cases has brought up a number of issues, which need to be pondered. We present her three cases as examples.

Case No. 1: Male, 46 years, A radical political activist, arrested in Calcutta in 1970 and detained under the Preventive Detention Act for about a year. He was subjected to violence during arrest, and during his initial month of police custody was tortured in order to extract information about revolutionary activities. Methods used including abusive interrogation which could continue for days together or taken place at any time of the day or night, deprivation of sleep, beating all over the body with sticks and fists, kicking and trampling with boots, burning with cigarettes and breaking the finger joints. The victim's house was ransacked, family members threatened and elder brother also detained.

No medical care had been available during detention except treatment for a broken thumb at the jail hospital. Under private medical case since release, he recovered to some extent and took up profession as a designer. But a couple of ears back, he relapsed into the illness that has struck him after torture. There is an excessive tiredness, spinal pain and stiffness of the torso. He can no longer work on the drawing board, and doctors, including the orthopaedic at the CCTV, cannot say when he will be go back to his professional life. With two children, he would have faced dire financial difficulties had not his wife been supplement family income.

Case No. 2: Female, 21 years. A young woman with college education and nursing training from a Muslim family of Murshidabad district. She had just started dreaming of self-dependent life after taking up a job at a nursing home, but is now so traumatised that she cannot step out of home.

In August 1998, she was cycling home after work through a public road. It was about 6 p.m. in the evening and the rains had just stopped. Trying to bypass a truck on the way, she skidded into mudwater, which allegedly splashed and spoiled the clothes of two Border Security Force personnel passing by. They immediately pounced on the woman who had fallen on the ground with her bicycle and started abusing and beating her with fists. The torture, on open road, continued until a local woman saved her. The blows mostly fell between the back of her head and lower portion of the body, as she had fallen on the ground face down.

After three months, of which the initial fortnight was spent in a hospital, the victim is still suffering from acute headache, sleeplessness, nightmare and the fear of being killed, and several other physical and mental problems. She reacts to even a pat as if to electric shock. The CCTV has placed her under neurological and psychiatric care.

Case No. 3: Male, 38 years. He was fired upon by the police at a busy street crossing on the northern fringe of Calcutta in June 1983. The firing was apparently aimed at quelling an agitating a crowd protesting against alleged police negligence over a traffic accident. The victim was not part of the crowd but a passer-by. A bullet pierced him behind the right knee. He was taken to a government hospital by local police, where he had to spend about a year. A limb-saving surgery was done. Nobody from the police or administration ever turned up during or after the hospitalisation, which had to be paid for.

Following release, the victim's condition has been fluctuating for the last 15 years. At present, his wound is bleeding and forming puss. There is increasing difficulty and pain with walking. The young man who had been self-employed before the incident is now totally dependent on his mother's meagre family pension. The CCTV has recently taken up the case sand is trying to provide specialist treatment.

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The injury, long hospital confinement, continuing illnesses, loss of income, dependency and frustration has caused deep anguish and traumas in then victim. This is a case of prolonged suffering of an innocent person caused by the state, tantamount to torture. And typically, the state has not taken any responsibility for the victim at any point.

Needs

The above studies, varied as they are in nature and context, underline the need for specialised medical and social support systems to the victim of torture. There is also a gap between the available knowledge on the effects of torture on the body, mind, livelihood and social/familial condition of the victims and the ground reality, which need to be addresses.

For any support group, there are three important and immediate functions:

Collection of information about torture cases and contacting the victims or their families;

Assessing the support available and required; and

Follow-up of each case with experts helps.

The scope for improving the support mechanism, particularly for those suffering from grievous injury, post-traumatic stress disorder and economical handicap should be explored in more depth.

While we should not shy away from fixing responsibility on the state and pressuring it for all possible forms of compensation, the civil society should form the backbone of this support structure.

If the civil society fails to take up this challenge it will only clear the way for its own derogation. After, all. Torture thrives on the culture of silence that is fatal to the civil society.

CEHAT, Mumbai, India

Paper: 15

Women and abortion rights in Nepal

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Background

Gender violence causes more death and ability among women aged 14-44 than cancer, malaria, traffic accidents, or even war.

The indirect cost of gender violence to development is extremely high. The negative impact of gender violence on women's reproductive health is only just beginning to be recognised. Domestic and sexual violence is reproductive health problems because they are intertwined with sexuality, fidelity, pregnancy and child rearing. Research suggests that physical and sexual abuse is the one linked to some of the most intractable reproductive health issues of our times: teenage pregnancy, unsafe sexual behaviour and sexually transmitted diseases including infection with HIV.

Reproductive rights constitute an important area having direct correlation and being with gender violence. The "womb" is seen both as a blessing and a curse for women. It stands as major constraint hindering mobility, personal, professional development for controlling politically empowered positions and even to the extent of earning their own livelihood. On the other hand for many women the ability to give birth to children have provided them safety and a sense of a secure marriage. On the contrary the "womb" has increased women's vulnerability to unwanted pregnancies arising from rape and involuntary professions as sex work.

Unwanted pregnancy and abortions is often an outcome of rape. Abortion is extremely dangerous in countries where it is illegal. Throughout the world 75,000 women die from excessive bleeding or infection caused by botched abortions every year, according to the World Health Organisation.

Nepalese law on abortion and infanticide

In Nepal there are no separate acts for dealing with trial and punishment for crimes of abortion and infanticide, nor are there even separate chapters in the national code. Nepalese law declares abortion a crime and prescribes punishment for the crime. Nepalese law puts a blanket ban on abortion. Intentional act of aborting under any circumstance is illegal and punishable except in cases where an act done with intent of welfare of the pregnant woman; results in abortion or causing abortion or helping to abort are unlawful and punishable. It is evident that even when doing something in the interest of the pregnant women, immunity is given only to an act which results in abortion (i.e. unexpected result) and not to any direct act of aborting, irrespective of the circumstances. Even a medical practitioner cannot intentionally terminate the pregnancy of a woman for health reasons. Because the law of the land does not permit abortion, it simply gives the doctor immunity from punishment in such cases where abortion is the accidental consequence of some other measure (not aborting) taken by the doctor for the pregnant mother's welfare.

If any person performs an abortion on a pregnant woman with her consent causing her to miscarry, both the persons performing the abortion and the woman are sentenced to one year or one-and-a-half years depending on whether the foetus is less than six months or over six months. However, for a person who performs abortion on a woman without her consent, the punishment ranges from 2 years for a foetus less than 6 months and to 3 years for a foetus over 6 months.

There is a serious anomaly in Nepalese law. If a woman who falls a victim of rape, kills the rapist as a measure of self-defence while being raped or going to be raped or as a revenge immediately after the rape, law immunises her from punishment, whereas the law does not permit her to destroy a pregnancy conceived as a consequence of rape.

Usually pregnant mothers who want to terminate their pregnancies are either married women who have conceived through adulterous relationship, or widows who have conceived through relationship or women who have conceived through incestuous relationship. If married women conceive through adulterous relationship, which often happens usually when their husbands go abroad and do not return after a long period, then the problem starts. If such relations should result in a baby, the women would be driven out of their homes, forfeit all rights in property find doors closed for them even in their paternal homes and be treated with contempt and completely boycotted by the society. Terrified with this prospect, these women desperately terminate their pregnancies through abortion thereby committing a crime and if they fail in their attempts and give birth to babies they often resort to the terrible act of killing their own new-born babies or abandon them to be even exposed to death.

Relationship of a widow with someone of her liking is not regarded unlawful in Nepalese law, yet a widow's relationship with someone is looked up with contempt by the society. A widow of a tender age is always looked with suspicion and fear that she may one day elope with somebody or contract sexual relationship with someone. Thus hated and treated with contempt from all sides she becomes vulnerable towards anyone who shows sympathy or love towards her and falls a prey to his lust. Even if a man is of affectionate nature, he, being afraid of disapproval by the society of his relations with a widow, hesitates to own her. As a result the unfortunate woman, hated and looked with contempt from everyone and now being abandoned by her lover, tries either to commit suicide or resort to crime of abortion or killing her own baby.

Even if any unmarried girl becomes pregnant through relationship with some man, society does not take it as an ordinary phenomenon, but begins to hate her and our social environment obliges her to try every possible means to hide her pregnancy out of public shame. Out of desperation she tries to abort her foetus, failing which she even may resort to the crime of killing or deserting the newborn baby.

As regards the punishment to the mother for killing her newborn baby or the punishment for infanticide is, as stipulated in the Chapter "On destruction of Life," is the punishment for homicide. The act of killing a newborn baby is certainly a crime. However the existing system of punishing the offender of this crime with the same maximum punishment for homicide irrespective of the circumstances in which the crime is committed is not just. Sec. 18 of the chapter states that if a mother abandons a newborn child and it dies of exposure, the mother is to be punished as a murderer. The crime of cruelly murdering a new-born baby and the crime of a mother who deserts her new-born baby somewhere or abandons her baby at the place where she has delivered resulting in the death of the new-born baby are not crimes of the same

footing, but in both cases, the existing law punishes the offender for homicide, the punishment for which is life sentence plus confiscation of her entire property. If the child does not die and is found by somebody, the punishment to the mother for deserting the child is an imprisonment of 4 years. Although the crime committed is the same act of desertion done by the unfortunate woman who is sentenced to life imprisonment as a result of the abandoned child's death.

As was revealed in two separate studies made about a decade ago by the two different organisations, IDS and Women's Legal Services Project, there were a little less than three hundred women prisoners lodged in various prisons of Nepal. They found that most of them (nearly two-third according to WLSP finding) were convicted and punished for crimes of abortion or infanticide. In reality a few hundred women prisoners constitutes only a negligible portion of the total female population of the country, but the shocking thing is the fact that two-thirds of them are languishing in prisons convicted or accused of committing abortion or infanticide. It is evident that the crimes are the results of unwanted pregnancies. It is also evident that the crimes of killing newborn babies are committed after failure in their attempt to abort pregnancies, resulting in the birth of babies. Hence if abortion laws had been liberal the crimes of infanticide would have been contained to a great extent.

A ray of hope beamed when His Majesty's Government presented a bill, which tried to liberalise the laws on abortion and to prescribe more rigorous punishment for crime of rape. The bill sought to permit abortion on the certain grounds, such as (i) within twelve weeks of pregnancy, on mutual consent of the pregnant mother and her husband (ii) within eighteen weeks of such pregnancy which is conceived through rape or incestuous relations (iii) if the medical expert recommends for abortion on medical grounds.

The bill also prescribes more rigorous punishment to the rapist, which would restrain the crime to a considerable extent. The bill also suggests some change in its procedure for trial of the rape case with a view to save the victim from embarrassing situation in the trail proceedings. But unfortunately the bill could not get through that session. A number of amendments were moved in the bill and it is still pending in the House.

Regarding laws on abortion, if the bill presented in the House is passed and turned into an Act, it will ameliorate the suffering of women to a considerable extent. Similarly if the suggested amendment in laws to punish rape is passed by the House, it will relatively improve the situation. It is equally necessary that the existing laws prescribing punishment to a mother who kills her newborn baby should be amended. It is to be borne in mind that a mother who kills her own baby is not a murderer with heinous criminal attitude, but is an unfortunate woman who has, out of desperation compelled by extra-ordinary circumstances resorted to the crime. Although she has a criminal intention in her act, the intention is different from that of a murderer and should not be awarded the extreme punishment meted out to a murderer. Through liberalisation of laws on abortion, making punishment for abortion and infanticide less rigorous and prescribing more rigorous punishment for a rapist, we can hope that violence against women will be restrained to a considerable extent.

CEHAT, Mumbai, India

Paper: 16

Violence by state agencies: Two case reports

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A medical man often comes across victims of torture (either by state agencies or by any other person). So, he must be aware of the ethical aspects of torture with special reference to declarations, principles and guidelines applicable to medical professionals.

Torture and violence have been identified with the police in India ever since the vedic age (2000-1400 B. C.). Kautilya, Manu, Gupta speak about it. Indian Penal Code (1860), Indian Evidence Act (1872), Criminal procedure code (1898) include in them the relevant sections as far as torture is concerned. But the Investigating Officers due to their over-zealousness and ignorance of recent means to investigate crimes take the resort of this 'simple way' of torture.

A doctor can be involved in the acts of torture in many ways like:
- As a humanist citizen,
- As a participant in the process of torture,
- As a victim of torture (e.g. in Chile, Turkey.)

Various declarations and principles regarding ethical aspects of torture are available including:
- Hippocratic Oath,
- Declaration of Geneva (1948),
- Declaration of Tokyo (1975),
- Statement by the International Union of Psychological Science (1976),
- Principles of Medical Ethics relevant to the role of Health personnel in protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment (1982),
- Declaration of Hawaii World Psychiatric Association (1983),
- World Conference on Human Rights (1993).

Doctors may face the dilemma whether to follow the ethics or obey the orders of superiors when such order is not basically illegal. The details on this topic will be discussed at the conference.

Two case reports are mentioned below, in which I was involved in the capacity of a doctor conducting the post-mortem examination.

Case report: 1

(The names and dates in these case reports have been changed as the cases are recent and *sub-judice*)

ABC, a 35 years old male was in police custody for some petty offence. On January 1, 1996, at 3 p.m. he became comatose and drowsy. There was hallucinatory behaviour and disorientation to time, place and person, He was admitted to xxx jail dispensary. By 5.00 p.m. on January 1, 1996 he was not responding to painful stimulus. His pulse was 64/min. and B. P. 86 mm Hg. (Systolic).

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In the jail dispensary they made the diagnosis of:

(?) Alcohol intoxication
(?) Withdrawal symptoms.

He was then referred to zzzz Hospital (A well established govt. hospital with a medical college attached to it) on January 1, 1996 at 6.25 p.m. When he was received in the casualty of this hospital, he was unconscious, pupils were dilated, sluggishly reacting to light, his B.P. was (?) 150 (systolic) and alcohol like smell was present in his breath. So, in the casualty again the diagnosis of (?) alcohol intoxication, (?) withdrawal was made and the patient was shifted to the ward.

On examination in the ward, right black eye was noticed and this finding was noted in the case paper. However, again a provisional diagnosis of alcohol consumption with sedative overdose was made. So, Ryle's tube aspiration was done. The sample was preserved and handed over to the concerned police. Treatment was started.

By 8.35 p.m. his spontaneous respiration stopped . He was immediately shifted to ICU and put on ventilatory support. On 2.1.1996 at 7.20 a.m. he went in deep coma. There was hypothermia. Pulse was not palpable, B .P. was not recordable.

A diagnosis of Unknown poisoning with cardio-respiratory arrest with (?) Anoxic brain damage was made. Throughout the day his hypothermia continued (Rectal temperature < 35°C). His condition did not improve and he expired the next day i.e. on 3.1.1996 at 1.15 p.m.

A police inquest was made on 3.1.1996 in the evening and the body was received in the dept. of Forensic Medicine of the same medical college on 4.1.1996 at 12.15 a.m. His post-mortem was conducted on 4.1.1996 between 12.30 a.m. to 1.45 a.m.

Post-mortem findings:

External:
Abrasion 0.5x 0.3 cm. over inner aspect of left side of lower lip, near the region of lower left lateral incisor and the canine teeth.
Contusion surrounding the lateral aspect of right eye.

Internal:
Below scalp haematoma 4x2 cm. over left temporal region
Haematoma present in whole left temporalis muscle.
A large 1 cm. thick layer of organised subdural haematoma, covering the whole superior and lateral aspects of both the cerebral hemispheres.
Haematoma also present at the base of brain and in subarachnoid plane.
There was fracture of 2^{nd} to 7^{th} ribs on left side at thierangles.
The whole posteriolateral surface of left thoracic wall was contused internally.
Thoracic cavity contained 100 cc. of fluid blood.
Gastric mucosa was normal. Stomach contained 30 cc. of yellowish sticky fluid without any specific smell.
Liver showed fatty changes.
The age of the injuries was 4 to 6 days before death.

Viscera was preserved and cause of death was given as "Death due to shock following Head Injury." Chemical analysis report of the preserved viscera was received on 8.4.1996 (3 months later) The following findings were present -

Ethyl Alcohol was detected in:
Stomach and Intestines: 30 mg/100 ml.
Liver, Spleen & Kidneys: 13 mg/100 ml.
Blood: 40 mg/100 ml.

The case was handed over to the state CID for investigation. They asked the following queries during investigations:

What was the age of injuries ?
→ Approximately 4 to 6 days before death.
Whether the injuries are possible by falling on a stone ?
→ Injuries are not possible by a simple fall.
The provisional diagnosis of alcohol consumption and sedative overdose was made in this case and also at one place in the case notes it was mentioned as 'Unknown poisoning'. What is your opinion regarding this ?
→ The alcohol levels detected in the viscera are too less and nowhere near the fatal dose of ethyl alcohol. Also no sedative or any other drug or poison was detected.

Thus, taking into consideration the indoor case paper, post-mortem findings, and the chemical analysis report, I am of the opinion that, "Death is due to shock following head injury."

Discussion:

The present case throws light on two important topics First and foremost is regarding the violence by state agencies. From the post-mortem findings it was clear that
The person was assaulted by hard and blunt object, and
The injuries were sustained when he was in police custody.

After receiving the post-mortem report, the investigation was handed over to the state C.I.D. and the matter was also raised by the National Human Rights Commission. All the police personnel who were responsible for the custody of the victim were immediately suspended and were booked under relevant sections of the I.P.C. Secondly, regarding the missed diagnosis of head injury, the patient was admitted at two places before his death. It is a well known fact that the symptomatology of alcohol overdose and head injury are similar. In fact head injury is one of the differential diagnosis of alcohol intoxication. So, when a diagnosis of alcohol intoxication was made at both the places, the concerned doctors did not bother to rule out the possibility of head injury, especially so, when the finding of right black eye was noted in the govt. hospital case notes, which we all know can very well be due to head injury.

Now, the question is whether the omission (to diagnose the head injury) was a deliberate one or just a case of missed diagnosis. One can understand missing the diagnosis at the small ill equipped dispensary level, but what about the full fledged govt. hospital with a well reputed medical college attached to it and which serves as a referral centre to all the surrounding districts. If this omission is deliberately done in such an institute, either due to pressure from the police or any other source or for monetary gains, then it certainly a matter of concern and steps should be taken to penalise such black sheep in the medical profession.

Case report: 2

A fax message was received in our department on 1.1.1997 in the evening from the deputy collector of xyz taluka, stating that a person ABC had expired in the police custody on 22.12.1996 (7 days back). His post-mortem was done in the Primary Health Centre of that taluka and the body was buried at the outskirts of the village.

The wife of the deceased has raised doubts about the authenticity of the first post-mortem report, as it failed to throw any light on the cause of death of her husband. The cause of death as mentioned in the first post-mortem report was " Opinion reserved, Viscera preserved."

The situation in the village was very tense during these 7 - 8 days, as the wife of the deceased and her supporters were constantly demanding for a re-post-mortem and there was a delay on the part of the authorities to take a decision. At last due to political pressure they decided to carry out the re-post-mortem and accordingly sent a fax message to our department.

On 2.1.1997 the exhumation (digging out the buried dead body from the grave) was carried out in my presence by the special executive magistrate of that area. The deputy collector of that taluka, the police inspector of the concerned police station and the deputy superintendent of the area were also present.

It was rainy season. (date of this case reports have been changed). The grave was located on a slope, so it was not water lodged, however water was accumulated at a short distance from the grave. The soil of the grave was moist due to rains on the previous night.

After exhumation the body was sealed and shifted to our mortuary for post-mortem examination. The post-mortem was carried out on 2.1.1997 between 6.00 p.m. to 8.15 p.m.

Post-mortem Findings:

It was a body of 35 years old male. The body was partly decomposed and partly showing the changes of adipocere formation. (It is a natural means of preservation of a dead body in which in damp, warm environment the body fats get converted into higher fatty acids. And thus the features are well preserved and the injuries can be recognised). Skin over the body was loosened and easily removable. Underlying body surface was white and waxy. The following injuries were noticed in addition to the post-mortem incisions of the first post-mortem examination over the head, chest and abdomen:

14 large contusions involving the whole back at places, both buttocks were completely involved, and posterior aspects of both thighs and calves were contused at places. (The details regarding the exact location, size etc. of the contusions can be made available if anybody is interested in knowing them.)
Evidence of extra-vasated blood below the layers of scalp in left parieto-occipital and right parietal regions.
Evidence of ante-mortem fractures at posterior aspects of both parietal bones.

The available viscera were preserved for chemical analysis and the pieces of skull bones were sent for histo-pathological examination. The following cause of death was given:

"Evidence of multiple contusions present over the body. Skull bone pieces sent for histopathological examination.Final opinion kept pending till then."

Chemical analyser's report was received on 15.1.1997.
Ethyl alcohol was detected in stomach and intestines (17 mg/100 ml.) and liver, spleen, kidneys (25 mg/100 ml.)

Histo-pathological report was inconclusive. Final opinion regarding the cause of death was given as: **"Death due to multiple blunt injuries with evidence of head injury".**

After receiving the advance death certificate, the police officers responsible for the custody of the deceased were suspended with immediate effect. And after obtaining the final cause of death they all were booked under section 302 of the I.P.C.

Discussion:

When the second post-mortem (PM), which was done 8 days after the first PM can reveal these findings, it is improbable that the doctor who conducted the first PM did not find anything to which death could be attributed. So, it is very clear that in the case a fake PM report was purposefully prepared either under pressure or for monetary gains. If the re-post-mortem had not been done then the first doctor would have given the final cause of death as alcohol intoxication as ethyl alcohol was detected in the viscera of the deceased , though in minute quantities.

The interesting part of this case was that the first post-mortem report as revealed to me by the state CID at a later date contained many injuries including the fracture of the vault of the skull which were written in my report. How did this happen? Why then the cause of death was kept as reserved? These and the remaining questions will be discussed on the day of the conference.

CEHAT, Mumbai, India

Paper: 17

Violence against nurses

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History of man is the history of violence. Man used violence as a means to an end, for system maintenance, assertion of power, exploitation, victimisation and to maintain inequalities (Sinha, N.1989) Violence against women is again an age-old phenomenon. It is universal. In more or less severity it is present in all the civilisations. Violence against women is committed not only by men but by women too. Women are victimised by family, society, nation at large, at home and at work places.

The majority of women take up jobs not for gaining equality and status in the society but to augment family income and to support the family financially. In India, women mostly take up jobs as Nurses and Teachers (Heptulla, N.1992).

Most of the women who join General Nursing and Auxiliary Nursing courses come from lower middle class and lower class and they are also the class that has highest number of practising nurses in India. The students who join B.Sc. nursing course are also from middle class and higher middle class. They represent the social strata where woman's status is low in family and in the society.

Violence is an act of illegal criminal use of physical force but it also includes exploitation, discrimination, upholding of an unequal economic and social structure, the creation of an atmosphere of terror, a situation of threat etc. (Sinha, 1989)

Violence against Nurses is an unlawful act of exploitation and discrimination carried out against nurses. It is present all the time or sometimes at work places so that nurses live under the atmosphere of terror and threat and with this the supremacy of other people is established over them.

Causes of violence against nurses are as follows

There are multiple causative factors and they are inter-linked with each other:

Nursing is a woman dominated profession and there is low status of women present in the society.

Lack of autonomy: Administrative decisions are made by non-nursing personnel, mainly doctors. Nurses have no control over themselves.

Lack of leadership qualities among nurses: Nurses do not take part in decision making for themselves. They lack the quality of leadership and motivation. The leaders do not come forward and pursue the authorities for their rightful dues and position. There is no separate directorate for nursing staff in most of the State Governments.

Nursing education and practice does not go hand in hand. In Medical Profession educationists are the senior practitioners in the field and they are responsible for patient care management. In nursing profession nursing teachers are not in touch with practice. They are hardly present in clinical area. Their knowledge and work is limited only to the four walls of classroom. Most of the nursing teachers are not aware of new skills and advances in clinical fields.

Nursing education so far has not been able to prepare good leaders who will work for the real professional upliftment.

Absence of role clarity and identity among nurses. Mostly nurses do non-nursing jobs at work, which may be of doctors or clerks, and nursing care is not provided to patients at all. Students and relatives provide nursing care to patients in big hospitals.

Lack of Unity and Commitment- Every one is worried about self and no one supports the nurses who are victimised by others. Nurses are not united to fight against violence.

Professional Organisations like TNAI have not done much in last 50 years to raise the standard of profession.

Lack of political will for the upliftment of nursing profession. The recommendations are not implemented of various committees like the Bhore Committee (1947), High Power Committee (1989) by the State and Central Governments.

The types of violence present against Nurses is as follows

I) Violence by superiors:
a) By Medical and non-medical superiors
b) By Nursing Superiors
II) Violence by Subordinates
III) Violence by relatives and patients

The nature of violence

The violence against nurses comes in the form of mental abuse, verbal abuse and threats at day to day work. Sometimes, it takes the form of Physical abuse also.

The medical professionals and nursing superiors takes pride in shouting at the nurses at work place in front of other people like subordinates, students, patients and relatives Nurses who are hard working, intelligent, vocal and tried to protest against such violence have been accused of robbery, theft and been removed from job in private hospitals. *One of the senior doctors said during his clinical round to a nurse that if I call my dog to come behind me, he will come, who are you to pretend that you are busy in some other work. In another incidence the doctor says to a nurse that this is not a red-light area that when you want you will work. Here you will have to work all the time. During the argument when the nurse tries to say something, the doctor says I will cut your tongue, as I am a surgeon so that you do not argue with me.*

In one of the hospitals, the nurses were getting allowances for doing shift duties especially night shift. When these allowances were stopped suddenly without informing them, 2-3 nurses went and asked the medical superintendent about it. *He replied that do you charge extra money from your husband for sleeping with him daily?*

The nursing superiors abuse the nurses more in front of medical people. One In-charge sister used to loose her temper every now and then and would throw anything at the nurses especially at nursing students like injection boxes when she would get angry. After this she would ask the victims to pick up glass pieces and clean the area in front of everyone in the ward.

The threat, which comes from subordinates especially from Grade IV workers, is very severe. Some of these workers threaten the nurses' life. They remind them that you have a young daughter at home and they will spoil her if nurses report about the servant's misbehaviour.

There have been incidences of Grade IV workers threatening the nurses that they will jump from 3rd or 4th floor if nurses report anything about their functioning to authority.

It is usual sight to see relatives and patients accusing nurses in the ward. One of the relatives pulled the belt and cap of one of the nurse when his patient expired.

There are many more incidences like this, which are occurring as violence against nurses at work places in day to day life.

There is a need to prevent violence to occur against nurses. The victimised nurses do not come forward to report. Sometimes even if they complain verbally, they do not give anything in writing against the culprit. There is a great fear of losing their job and character. There is lack of support from the co-workers and nursing superiors. In the time of crises nurses generally do not stand together. The ultimate authority is with non-nursing personnel who try to dilute the incidence and are not interested in punishing the culprit.

The professional organisations are functioning only for name's sake and there is lack of interest shown by the Office bearers of such organisation in fighting against the violence.

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CEHAT, Mumbai, India

Paper: 18

Cases of torture by police outside the jail premises

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P. Singh (aged 28years) from Wardha, came with a clavicle fracture in his right side. He complained that he was beaten mercilessly by the police. His X-ray showed a clavicle fracture, which was confirmed by a civil surgeon at Nagpur. He was then treated through routine check-ups.

M. Nasir (aged 26 years) from Akola jail, who complained that the police beat him, had fractured lumbar vertebrae. Both his legs were paralyzed. He was referred to the Government Medical College for an X-ray. He was then placed in a plaster for about six months. Although, both his legs gradually showed improvement, he could only walk with the help of a stick.

T. T. R. (aged 24 years) came to the ward. He could not walk as he was beaten with a stick on the soles of his feet. His X-ray showed fracture of the metatarsals.

I. S. P. (aged 22 years) complained of pain in both the calf muscles. This was due to severe beating on both his feet by the police. He was diagnosed to be suffering from o/e heamatoma and he complained of severe pain whenever his feet were touched. He was cured through routine treatment and he got relief. His X-ray, however, showed an fracture.

S. N. D. (aged 27 years) arrived at the hospital from the Sacner police station with his left shoulder drooping. His X-ray taken in the Government Medical College revealed that his left shoulder was dislocated. After medication he got relief.

Bayabai T. D. (aged 36 years) was admitted to the female ward with severe chest pain in her left side. She was in tremendous pain and was unable to breathe easily. Her X-ray showed that her 7th, 8th, and 9th ribs of her left side were fractured. However, her E.C.G. was normal. After being treated for a fortnight, she felt better.

Gauri T. S. (aged 21 years) complained of severe pain in both her thighs and legs. O/E several concussions on both legs. Treated routinely. Without complications.

B. L. G. (aged 23 years) came with severe pain in both thighs and legs. O/E several concussions on both legs. Treated routinely without any complication.

A. R. (aged 29 years) was brought to the hospital in the morning complaining of severe pains on both palms of his hands and soles of his feet due to severe beating. He was referred to the Government Medical College for fracture. There were no fractures on X-ray and he was treated routinely.

I come from Nagpur. I am a retired doctor from Government Service from Maharashtra State. As I was working in Nagpur Central Jail during last 3 years of my service, I am narrating some of my experiences during my tenure as Chief Medical Officer (CMO) in Central Prison in Nagpur. Inside the jail premises there is a big compound of jail hospital having different wards

for the patients. Very serious patients are referred to Government Medical College for investigation and treatment. There were two more doctors, a compounder and a male nurse to assist me.

Torture

Torture is a comparatively new subject in medical science even though it has been taking place in human society since time immemorial. In 1974 Dr. Ingo Genefke and her associates formed the 1st Amnesty International Medical Group in Denmark in response to an appeal made by Amnesty International at its conference held in Paris, 1973. I have worked in Medical Department of Maharashtra State from 1951 to 1987. During the last three years I was posted as CMO. I saw several cases of torture by government personnel like police.

The World Medical Association, in its Tokyo declaration in 1975 has defined torture as the deliberate, systematic or wanton infliction of physical or mental suffering, by one or more persons, acting along or on the orders of any authority to force another person to yield information, to make a confession or for any other reason.

Intentional: Torture causes physical or mental suffering to the victim deliberately. When a person slaps his/her child out of anger and apologises afterwards it is not considered torture since he/she does not do it deliberately nor did he/she have any intention of causing physical or mental suffering to his/her child.

Systematic or wanton: The infliction of suffering on the victim could be preplanned. It could be wanton and random. I had seen multiple fractures of legs and hands of a newly born child made by this stepmother.

Order or no order: An order to torture is not an excuse for torture.
Purpose: There should be a purpose for the torture. It may be to obtain information, to force him to confess the crime or to sigh a written statement, or revenge.

Physical or mental sufferings: This definition clearly mentions that physical as well as mental suffering should be thought of while examining an individual to see whether he/she was tortured or not. Absence of any physical signs or torture alone does not rule out the possibility of torture. Psychological or mental status of the case is of equal importance. Even minor physical or mental suffering in the presence of other criteria is enough to constitute torture.

Aims of Torture: As discussed above in definition of torture it is essential to have some purpose or objective behind the torture. If there is no aim or purpose it does not constitute a torture by definition.

There are many reasons for torture and this varies from case to case depending upon the charge against the victim and his/her personality. Some of the purposes of torture are as follows:

To obtain information: After arrest, a person is usually subjected to torture in order to get information about his/her activities and the persons and organisation involved therein. The person is tortured till the information is obtained. If the information given is found to be incorrect he/she will be tortured further.

To force confession: The victim is forced to sign a written statement saying that he/she has committed crime.

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To get a testimony incriminating others on the basis of which other persons can be arrested.

To take revenge: Person is tortured to take personal revenge too. His family members, wife and others.

To spread terror in the community: Very often seen in dictatorial regimes. Anybody who dares to raise his voice against the ruler or the regime is tortured mercilessly. Sometimes the victim is killed and his body is sent back to the community and with the physical and mental signs of torture. This creates terror in the community and nobody dares to rise up against the regime. The dictator then manages to continue his/her dictatorial rule in the country. Edi Amin of Uganda.

To destroy the personality: There are always some people with leadership qualities in every community. These people dare to raise their voices against the dictatorial regime or opposition in the society and motivate and mobilize people in the community against these evils. These people are identified, arrested and tortured in such a way that they become like the living dead. Behaviour, thoughts and feelings all change dramatically. There is loss of self-confidence, and a sense of hopelessness, helplessness and worthlessness.

My routine as CMO:

I used to go on my duties early in the morning about 8 o'clock, sign the register, go through the second gate while passing near the food preparation room. I was requested by the Jamadar in charge to see food, which was put in a clean thali, and kept inside the glass almirah, usually common houseflies were very few. I had to test the food and had to certify that the food – chapatis, rice, dal and sabji - were in good taste and had to sign a register daily except on holidays.

During morning hours I had to visit the ward consisting of about 30 patients who suffered from fever, dehydration, fractures and other ailments. T.B. ward was separate. T.B. cases were sent to Government T.B. Hospital for check-up and X-rays. They were given medicines as per schedule for the T.B. treatment.

There were other wards for skin infections like leprosy, scabies, etc. They were given daily treatment. The staff included two compounders, male nurse attendants and one jail guard.

Very rarely, I was called to scan emergency cases. One day, early morning, I was called to see one case who had hanged himself to a branch of a guava tree. O/E patient was nervous and sweating. C.V.S and R S. system were normal. BP and pulse were regular and normal. He was sedated and carried to the indoor wards, where he was given sympathetic words and sedation. Especially milk was given to him both times. He was better in a fortnight and later on sent to barracks.

I have not noticed during my three years of time any harsh beating by outside police coming inside the jail. The jail staff was also managing the victims in a gentle manner.

Teacher was visiting in the morning, who carried mass prayers and Bhajans etc. I have seen a library inside the jail, which contains sufficient books in English, Marathi and Hindi, some of which I have read.

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There were other occasions like Dassera and Diwali festivals during which the victims were taking part in the festivals.

Annual games' festival was held in the month of December and January where all the inmates took part.

Some convicts were donating blood by which they were getting reduction in their sentences.

In short, my stay in the jail as a CMO was without any bad incident. Both jail staff and convicts were pleased with my work. When I retired I was given a warm send-off with trophy for my good work. I have not seen any jail staff torturing any victim inside the jail

I have certain suggestions to offer for better doctor-patient relationship. It will also minimise the occurrence and recurrence of unpleasant episodes. These suggestions are:

Sympathetic listening to the problems of the patients with methodical bedside examination is important. Be within the reach of your patients. Offer maximum benefits with minimum costs. Investigation should be done whenever and wherever necessary. This is one of the trust-building steps.

Better and timely communication is needed. We should very frankly tell to the attendants of the patients about the gravity and prognosis of the disease, more so in the serious patients, which will make them mentally prepared to face any eventuality likely to occur.

Psychological dressing in terms of behaviour and treatment is meaningful and fruitful, love; compassion and sympathy give healing touches.

Tactful handling in issuing medical certificates and conducting medico-legal work is very important. Never issue any medical certificate anti-dated. False certificate may cost him cancellation of his registration. Never fall prey to any temptation. Once you establish your reputation none will approach you for concocted reports.

Last but not the least, we should have a disciplined tongue, thereby protecting you from consumer protection Act. Many cases are going to and pending in consumer courts because of irresponsible behaviour on our parts.

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Paper: 19

Violence against women in Tajikistan

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Tajikistan, one of the countries in Central Asia, is boarded by Uzbekistan, Kyrgyzstan, China and Afganistan. Its territory is largely mountainous and divided into three provinces. Apart from the capital Dushanbe (around 6,00,000 people), the only town with sizeable population is Khujand (around 1,57,000 people). With an area of 1,43,000 sq. km (about the size of Greece) and a population of 5,6 million in 1992, Tajikistan has the highest rate of population growth--2,9% in the former Soviet Union, the lowest per capita GDP in the former USSR and extremely low standard of living. 80% of population are Muslims. Agriculture dominates the economy, cotton being the most important crop.

Violence against women

This crime which affects thousands of women each year, is become evident. The types and forms are different. The victims, however, are the same: women and girls. The perpetrators are the same: their families, their communities, the State in which they live. The result is the same: installing fear, insecurity, violating the human rights.

Imagine that you are one of the women who are being raped during civil war in Tajikistan. Imagine that not only you are a woman subjected to the various type of violence against women but that you have absolutely no way to seek redress or punishment in the country that you live in.

Recently the research was done by our Association with a random sample of 1000 women in Khujand, Tajikistan. It showed, that:

30% had suffered physical violence "more severe" than being grabbed, pushed or shaken from current or former partner
27% had been injured
27% had been threatened with violence
23% had been raped
37% had suffered some form of mental cruelty
12% had suffered physical violence during the previous 12 months
30% of these women had experienced six or more attacks during this time.

Only one year ago we had no rape crisis, no women Centre, no transition houses. When women were attacked, a few women survived but each was on her own to seek what help she could find among family and friends. Wives beaten and raped by husbands had no legal or social resources. Police openly dissuaded women from reporting, told them to stop provoking male rage and identified easily and boldly with male abusers. Prosecutors were ineffectual in aiding women either by securing conviction of their abusers or by preventing further attacks from occurring. Doctors did not know how to examine women for internal damage or how to collect forensic evidence in court. Psychiatrists normally promoted compliance from women with

theory and practices built on blaming woman. They claimed that incest victims were imagining the torture or were the cause of it. Women struggled to overcome these "private problems" with private solutions.

But a new day is dawning. In Tajikistan women have gathered several times to discuss the shape and nature of violence against women. So, in 1995 it was decided to set up the Crisis Centre to victims of violence in Khujand, Tajikistan. Since May 1997 Crisis Centre's activity is supported by TACIS (European Union) within the framework of LIEN Program and implemented under the partnership of Mercy Corps International (his regional office in Uzbekistan, Tashkent). We have continually impressed by the energy, creativity and dedication of the staff of Mercy Corps International.

The main objective of our Centre is to improve women's material, psychological and social well being. We want to assist women who have limited access to health and social service institutions; those who are victims of violence and feel morally and psychologically dressed.

Firstly we installed a "hot-line" at our Centre. 256 women, mostly middle and upper class Tajiks, have called the hot line for assistance during that last 3-month. Among them there were a greater number of unemployed women from the public sector, women who are financially dependent on men. It was the reason that Centre has to concentrate on women's employment issues, encourages them to start entrepreneurial initiatives, or helps them to return to the labour market by upgrading their qualifications to meet present day demands by offering training or retraining Programs.

As we noticed, many women do not contact the Centre, as they are afraid of being found. The help-line is a vital service for women who for whatever reason cannot contact other places. It provides ongoing support for as long as women need it. Help-line staff and trained volunteers answer phone calls from hundreds of women each month. They can give advice and information as well as a much-needed listening ear. For many women who have called, this is the first time that they have told anyone about what is happening. Sometimes women call several times over a period of time. Some know straight away that they want to leave, others take longer. Some have their own means of leaving and do not need to come for face to face counselling, some do not leave but use the Help-line as a source of support when making changes in their relationships. We have broken the isolation of women by listening attentively and supportively. We have believed women and avoided the trap of considering victims to be sick or weak or unwise. Instead we have added what they could to resources that might help women to recover, understand and reclaim their rights in a life of independence. We have built a group that trusts each other and accounts to each other. They have used their own stories to help and assist other women, refusing to hide behind their position or pretend that they do not suffer from the same violence and threats of violence.

Besides it, we worked out the methodology for offering training concerning personnel issues and self-defence; several trainings for women suffering from psychological depression were held. Women's self-defence is not a form of wrestling, as it is sometimes thought. An important part of it is not so much the physical exercises as the spiritual strengthening exercises. Women first of all are taught self-confidence, how to avoid risky situations, how to say "no" so that they are understood, and how to use what they have - body, language, voice, wits. As our experience has shown fear of violence stops women in her professional development and realisation of her abilities, changes her behaviour and aims of life. So, this training helps women to know how to use their inner strength in order to carry the burden of the household, of work, of responsibility for the family. A self-confident person is less often likely to become a victim.

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Often victims of violence required legal consultation, which the crisis Centre helped them to find. Special rehabilitation and medical services to rape victims and depressed women, legal counselling, hot line, training on self-defence - this is the first steps of our operation.

Besides progress we have some problems. Most of the problems concern lack of experience and the inadequacy and limited number of information on the subject on Russian and Tajik. The delicacy of the subject matter requires a tactful and culturally sensitive approach to problem solving and issue facing.

In my presentation I also tried to explain why it is so very difficult to do away with family violence in our society. In my opinion, we need to overcome two thresholds in order to combat violence in the family: the first - to comprehend that family violence is a problem, that this is a widespread negative manifestation, and secondly - to step into the sacred family circle if human rights are being violated, if weaker members need to be protected.

The social service should respond to women suffering violence from known abusers, by developing and implementing good practice guidelines, monitoring the of services by women experiencing domestic violence, including the issues in basic practice, developing in-house practical services and options for women and children, using current legislation to displace abusing men if possible, taking part in multi agency liaison, publishing information, organising training and developing a personnel policy to cover worker safety.

.The centre's first steps indicated that there is a need for such centres

Democratic changes in Tajikistan made the problem of violence unhidden. Research in this field and development of a strategy to struggle against violence must be encouraged by state. It is necessary to create a special service to help victims of violence, joining efforts of governmental and non-governmental structures.

In conclusion, I just wish to raise one point which seem valid. It concerns the fact that although women can be demonstrated to make a significant contribution to the reconstruction of societies emerging from conflict, their efforts are often undervalued and marginalised. There is thus a clear need to involve women more directly in the rebuilding process, to build on and support their particular priorities and approaches, and to find ways to improve their socio-economic position.

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Paper: 20

Violence and the minds of women

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Violence against women (VAW) is a widespread phenomenon, which affects women of all classes, castes, race, age and religion. No woman, rich or poor, educated or uneducated, young or old, is spared from some form of violence or the other. VAW takes different forms - physical, sexual and/ or emotional. However it is important to note that when a woman is physically or sexually abused, she also undergoes mental torture.

Swayam is a Calcutta based organisation, committed to fight VAW. At the Swayam crisis centre, we get women from all strata of society visiting, calling, or writing to us about their problems. We get cases of rape, sexual harassment at the workplace, community violence and family violence too. Usually family violence is thought to mean 'torture of a woman by her husband and in-laws'. But, in reality, the torture faced by women in their natal family or in the hands of their own offspring is also a common occurrence.

It is not surprising that, as a result of violence, women experience serious health problems. The effects of abuse take the form of both increased physical illness and emotional disturbances or both. They may become depressed, lose their sense of reality, withdraw into their own world and become non-communicative, or suffer from trauma and face many other such severe consequences. I will put forward a few case studies to illustrate the effect of violence on women's health.

Case study I

Bharati called up Swayam office after reading in a newspaper that the organisation worked with women facing violence in their lives. She said that she did not know whether what she faced could be termed as 'violence'. Her husband was suspicious by nature and used to insult her even if her brother-in-law talked to her. He did not let her go out of the house. He dictated to her what she should wear. An engineer by profession, he would make calls from his office to check that she was home obeying his orders. When their son started going to school she was "given permission" to bring him back after school was over. Her husband often came back home unexpectedly to check on her, and would go through her bag and other personal belongings to see if he could find any other bus ticket. One morning, Bharati felt so depressed that she tried to kill herself. But her son woke up in time, and she could not light the match over her kerosene soaked body. Later on she was admitted to hospital due to severe mental depression.

The frightening thing about Bharati's case is that because it is a case of only emotional abuse, it is very difficult to make other people understand its importance. It is almost impossible to take any legal action against such a violation of a woman's right to mobility and space. The police also avoid taking any action in such a case because there is no 'visible' proof of violence. It is to be noted here that Section 498A of the Indian Penal Code says that cruelty by a husband or his relative, either physical or mental is a cognizable offence.

The doctor, who treated Bharati when she was in the hospital, however played a very positive role. He realised that it was not Bharati's fault. He did not ask Bharati to put up with the abuse and try to adjust with her husband. He spoke to Bharati's husband and told him that if he repeated his behaviour, he would report the matter to the police and take legal action against him.

Case study II

Ms. Das is a 55-year-old woman whose husband passed away 2 years ago. She stays with her son and daughter-in-law in a large 2-storeyed house, which her husband built before his death. Her son wants her to leave the house so that the whole house becomes his own. He comes home every night, shouts at her, calls her names, threatens to kill her, breaks glass windows and furniture while she sits frightened in her room, locked from inside. Ms.Das lives in a constantly anxious state. She began suffering from high blood pressure, chest pains and indigestion after these attacks started. She remains sleepless through the night thinking that her son will break her door open any moment and come in and kill her.

Ms. Das asked her relatives to intervene. In front of them her son made-up a story so that the problem looked like a mother-in-law - daughter-in-law quarrel. The relatives also believed in what he said. Ms. Das also asked the police for help, but they said it was a' family matter' so they could not intervene. They also felt that the trouble was actually with Ms. Das's daughter-in-law, even though Ms Das said very clearly that her daughter-in-law did not have any role to play in it. Her doctor feels that her physical health problems are definitely related to the abuses she faced. But no one is willing to look at this problem as a social problem. The blame is being put on another woman's shoulder without any hesitation by the society.

Case study III

Mala is a middle-aged widow living with her three children in the suburbs of Calcutta. Her parents married her off to a much older man when she was 13 years old. When her husband who was a fitter in the Calcutta Port died, he left behind a house in her name. She was only 25 years old at the time. As a young widow, who could barely read and write, living with three kids, she drew the attention of lot of people. Her relatives, neighbours and local political leaders could not accept the fact that she owned some property in her name. Further, men always look at a single woman especially if she is widowed, separated or divorced as 'fair game' or 'available'.

They were interested in grabbing both the property and her body. When they could not find any avenues to reach her, they started abusing her verbally whenever she came out of her house. They called her 'prostitute', made obscene gestures, and several men also made sexual advances towards her.

Mala considers herself a dirty object now, and feels guilty that men think of her as easy game. She remains in a constant fear that she or her daughter will get raped any day. She has also lodged complaints with local police station and councillor. No one takes her complaints seriously, as she is showing symptoms of psychological disorder. She is regarded as a 'crazy' woman and her abusers get away without any rebuke.

We have found that emotional abuse has a deeper impact on women than actual physical battering. Most of the women who come to us say that the scars from physical abuse heal, but the scars in the heart remain. They start thinking that as individuals they have no value. The

terrible thing is that sometimes they do not even feel or realise that they are facing violence. The major components of emotional abuse are Degradation, Fear, Objectification and Deprivation. Degradation is the perception that as a human being one is less acceptable than others. It causes deep pain and shame about oneself. Another common feeling is the anxiety of one's physical well being. Another form of emotional violence is to treat a woman like an object. Jealousy, restriction on social contacts and invasion of woman's space outside the relationship suggests that the woman is a property owned by the abuser.

Most of the women we counsel at Swayam have very little self-esteem. They have stopped considering themselves worthy of love, respect and fair treatment. They also show signs of loss of identity. Repeated abusive behaviour has taken away their ability to assess their own personal characteristics and values. A number of women who come to Swayam are in a perpetual state of depression and very often talk about committing suicide.

Mala often asks me "Didi, am I mad?" She needs help from mental health professionals. But she is afraid to avail of this service, as this will brand her as "mad". Once a woman is branded 'mentally disturbed' it becomes difficult for her to get any legal redress. In fact, it is very common for the abuser to take advantage of this attitude of society. Women often complain that their husbands want to take them to psychiatrists and get a medical certificate saying that they are mentally ill. This certificate will help them to evade a police case and can be used against the women if a legal case is registered. There are instances of men trying to get a divorce using such certificates.

It is interesting to note that in Case study I and Case study III, the issue that comes to mind, is that of a woman's chastity. The abuser is the 1st case wants his wife to remain a "good woman", so he tries to keep her confined within the four walls of the home, where no other man have an access to her. In Case study III, however, the question of chastity arises after the husband dies. Since Mala was a young widow, society was very keen to give her sexuality a test especially when the local people saw that although she was not financially well off, she was not dependent on them in any way. From the time Mala's husband died her neighbours assumed that they were her `guardians'. When Mala refused to submit to their control they branded her a `loose woman'. This would ensure that Mala became a social outcast -- an unchaste woman.

Case study II and III bring forward the issue of the reaction of society to property owned by a woman. Patriarchal society finds it difficult to accept that a woman can own property, because a woman herself is viewed, as property owned by the family/community. So, violence inflicted on the woman is justified in order to grab the property.

When we talk to mental health professionals regarding the cases where a woman is mentally disturbed, we always hear that the root cause of this problem lies within the woman herself. This makes us hesitant to seek advice from them because we feel that the violence the women face is a non-issue with them. It is true that different women react differently to the violence they face. But to say that a woman became mentally ill only because she could not cope with the abuse is definitely a statement where the abuser's role in the whole process is completely denied. Once again, the blame is shifted to the woman's shoulder and the abuser gets away with his abusive behaviour very easily.

Take the case of Leela. She was married at the age of 13. Within the first month of marriage her husband beat her up so badly that she became unconscious and had to be hospitalised. After this she went into a depression and would keep weeping and crying. This would alternate with her becoming violent, talking excessively and running away from home. After two years of

treatment she is still uncontrollable and doctors feel she will never recover. To say that Leela was unable to cope with the violence and hence is responsible for her present mental state is quite ludicrous. We need to bring home the point that it is the violence and the abuser that are responsible for her state, not the woman herself.

Whilst working with women, we see that their children are also badly affected by the violence they witness or are subjected to and react to it in various ways. They either begin to imitate the behaviour of the abuser, or hate the abuser, or hold themselves responsible for the violence. All these responses have disastrous consequences.

We have worked with a woman whose fourteen-year-old son tried to commit suicide because he could not cope with the violence at home. In another case, a woman's ten year old daughter told her one day, after witnessing her been tortured regularly, 'Ma, why don't you mix poison in Dad's food, so that he dies and we can live in peace'. She had to be sent away from home because she was serious about wanting to kill her father.

Violence against women thus has far reaching consequences, not only on the woman herself but also on her children. Strategies to deal with VAW can be worked out depending on the point of view one holds on VAW. Accepting that it is the abuser's behaviour that is responsible for damaging the woman will enable the woman to stop blaming herself. The woman's confidence has to be built up so that she feels that she is able to tackle the violence.
We feel that the mental health profession that has people like Bharati's doctor can prove to be a strong ally of women and the women's movement.

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Paper: 21

Intervention in health by Halo Medical Foundation in earthquake disaster in Marathwada.

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Earthquake shattered the lives of many in Latur and Osmanabad districts in Marathwada at early morning on 30th September 1993. More than 10,000 people died and about equal number of people had been injured. Not only they were emotionally shocked but on the other hand their livelihood was at stake.

As in all disasters, women and children suffered seriously. **1482 children became partial or total orphans and 444 women became widows.** Problems of the widows were severe. As per the survey conducted by Tata institute of social sciences **5116 persons had fractures. Initially there were 52 patients of total paralysis. Initially 784 people were under psychic disorders amongst them female were more than 80%.** After the earthquake problems of women, children were getting attention of all.

Our place is just 30 kms. away from E. P. Centre. We (Dr. Mr. and Mrs. Ahankari) are practising at Anadur since April 1983. Dr. Ahankari started working as representative for Voluntary agencies for Osmanabad district. Doctors and students f Halo Medical Foundation were very keen to work.

The activities of Halo Medical Foundation were started in response to the needs of the people in the earthquake affected area of Osmanabad and Latur district. Immediately after earthquake, everyone rushed to the place to help in one form or the other. Government itself and many NGOs left no stone unturned to bring about the relief work and bring their life to normalcy. Health, housing, agriculture, education, rehabilitation and almost in every field relief work was carried out. But as the time passed by, the tempo of the people calmed down. But on the other hand questions of permanent housing, rehabilitation, orphans, physically and mentally disabled, **primary health care** etc., remained unsolved. It was necessary to have a long term program in every aspect of rehabilitation process. Halo Medical foundation has already thought to work in health in earthquake affected area. We thought to use perceptiveness of village people to give permanent village level health program. This primary health care approach is based on community participation, inter-sectoral co-ordination, equitable distribution and appropriate technology.

Today we emphasise a lot on preventive and promotive as against curative medicine. Further, it will be community-based medicine. It is the community, which must be conscious about its health, and it must participate whole-heartedly in the various schemes for its health promotion.

This calls for better socio-economic and technical management of VHW program. About technical aspects there is an urgent need to establish a comprehensive and useful roll in village level health worker bringing more skills and greater knowledge base in the program. Further, it is necessary to create formal system for training, which will help and universalise the program.

Considering all these aspects, Halo Medical Foundation has launched Bharat-Vaidya (village level Health workers) programme which is women and children centred in the earthquake affected area.

Bharatvaidya training programme

The programme evolves around the basic faith that nearly 70 to 80% of the diseases can be treated and presented at the village level itself. A village level health worker-"Bharatvaidya" if adequately trained can take care of the health very efficiently. A syllabus is prepared for training consisting of 21 days of initial training followed by 2 days refresher course. The training is conducted at the centre in Anadur built by the foundation.

Until now the foundation has trained 85 health workers belonging to 80 villages. At the end of training medicines kit is provided to the worker

The duties of the worker can be summarised as follows:
Conduct Health Survey of Villages.
Treatment of minor and medium illness.
Births and deaths registration
Antenatal case Registration, examination and immunisation
Daily House visits, Health education sex education for AIDS awareness campaign
Identification of high risk cases and timely referral
Conducting Deliveries
Work for better environmental sanitation
Organising Mahila Mandal and formation of self help groups.
Co-ordinate with state Health services

The medicines are purchased from Locost, Gujarat. The worker is supposed to charge the patient as per the rate card provided to her. This is an attempt to make them self reliant. It is very much interesting to learn the work done by these workers (Annexure I).

The Bharatvaidya workers write a diary regularly is part of their duty. The socio-economic cultural dimension in their individual life has undergone drastic change. Ultimately the aim of upliftment of women's status in society, women empowerment, such issues are also taken care of Bharatvaidya workers have now established their credibility in the community.
Bharatvaidya workers carried out AIDS awareness programme effectively in this area.

Aarogya yatra

Immediately after the earthquake, the habitat of the villagers was changed. They had to leave their old houses and settle in the new open field where facilities of sanitation, drainage, bathroom, latrines were not available.

In the rainy season fear of various communicable diseases and skin diseases was seen. To create the awareness regarding the forthcoming infectious diseases e.g. gastro-enteritis, Hepatitis, Cholera, Scabies, " Aarogyayatra" (Health Tour) was arranged from 4-6-94 to 14-6-94. It was intended to carry on massive health education in earthquake affected villages. Thirty medical students from HALO, Govt. Medical college, Aurangabad and Dr V.M.College, Solapur and senior doctors stayed in Lohara for 10 days and conducted this yatra. Ten artists of Savadhan Kalapathak Anadur were accompanied. Daily two villages were covered Handbills,

poster exhibition, slide and film shows were arranged in this yatra. On various Health issues Dramas, Songs, street plays were performed by Kalapathak in villager's traditional languages. The impact of the Yatra was very much positive. Entertainment through kalapathak was the first occasion of enjoyment for the villages after the earthquake.

In the yatra 6000 handouts with information on communicable diseases were distributed. Survey on use of mediclore for purification of water was conducted.

Sanjivani mahila bachat sangh

The present project is women and children centred. We are now working in 40 villages. To make the project self-radiant the emphasis is given on women's organisation. Self-help groups are the best media for women to come together.

After discussion with many women's group the bylaw for regular working of SHGs have been devised by them. About 7 to 11 women come together and form SHG. They select one woman as chairman and one as co-ordinator. They collect Rs.25/- as contribution per month per head. So far 32 SHGs have been formed in 25 villages. We have brought all these groups together under federation and named it as Sanjivani Mahila Bachat Sangh.

The Sangh pays 10% interest on the savings and gives loans (family credits) to the members of SHGs. Halo medical foundation has raised some revolving fund to give the loans. For every group three times more of their savings, loan has been given.

In a village the rate of interest on loan by landlords varies from 7% to 15% per month. Even though the interest rate is so high, the loan is not easily available. The loan from the Banks is available for specific purposes and to specific groups only. Many a times there is urgent need of money as in sickness, education, deliveries of daughter's etc. Sanjivani Mahila Bachat Sangh grants loan up to Rs.2, 000/- for any familial problems. The Sangh gives loans above Rs.2,000/- for income generation activities. The detailed report is annexed.

Bharat Vaidya program is the first prime activity of SHGs. Members of SHGs participate actively in village level health workers work. We intend to hand over all health activities to SHGs. The loans to the members are being given on 2% rate per month. The Sangh gives 10% interest per an7um and collects 24% interest per annum. On the difference as 14% profit the project activities will be continued. Various activities by SHGs have been carried out in last year. They have participated in Independence Day and Republic day. Traditional religious activities as Haladi Kumkum, Sankrant have been used for health education. Public programs as dramas, songs, folk songs, have been performed for mass level education.

338 women of 32 Bachat groups have become members of Sanjivani Mahila Bachat Sangh. Out of these 259 women have borrowed loan so far. This power of economy has brought about a magnificent change among the women self confidence, self respect, self reliance and independent decision making. This is just beginning.

Social intervention

We could witness all the mishaps and the turmoil and the process of rehabilitation in earthquake affected area since beginning, as we belong to the same area. Here are some examples.

Rajendra and Vimal Deshmukh of Sastur had paraplegia after injuries in earthquake. Both of them were under treatment in hospital. Rajendra recovered and could carry on routine activities and Vimal was still bedridden. Rajendra remarried. What about Vimal's life? Dhanubai Hasure of Sastur was ready for hospitalisation for her paraplegia. She feared that if she leaves the house her husband would remarry. Vithoba Kumbhar 67 years old, from Kondajigad lost his wife and he married young girl who was 17 years. There are many such examples of remarriages of widowers but out of 444 widows only two could get remarried. Pandoba Kambale from Holi was staying in farm because he was a Leper. After the quake she rushed to the house and rescued his family members. Every body was grateful to him. But after few days Pandoba's son told Tahasildar that his father died in earthquake to avail the compensation. Thus Pandoba was not only chucked out of the house but declared dead.

89 injuries became permanently handicapped. Who needed proper rehabilitation? Management of paraplegic at home in temporary sheds was big problem.

Looking at the spectrum of problems. HMF arranged for counselling village meetings, Group discussions that enhanced people's participation in the process of rehabilitation. We were working as executive member in NGO co-ordination committee where HMF did very important role in advocacy for policy decisions to be taken by State Government.

Halo medical foundation aurangabad, Bharat vaidyak training centre, Anadur:

Work done by Bharatvaidya workers

Year	**1/1/95 to 31/12/95**	**1/1/96 to 31/12/96**	**1/1/97 to 31/12/97**
a) No. of pts. Examined	6671	6850	9063
b) No. of referred pts.	432	442	338
c) Cost of medicines collected	6996	6540	14832
d)Pregnant Women, registered & immunised	1841	1198	872
e) High risk pregnant Women identified	237	241	165
f)Birth Registered	705	521	657
g)Deaths registered	259	213	208
h) No of workers Monitored	54	35	32

Paper: 22

The law and homosexuality in India

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While talking about law and homosexuality, I am reminded of a story of a washerman and his donkey. The donkey refused to move with the heavy bundle of clothes on his back from his house to the pond. The washerman nailed a carrot to a stick, which was tied in front of the animal's mouth. The donkey kept on moving with a view to eat the priced vegetable – the ass goes on and the carrot is un-reached. In the field of jurisprudence this shows how some laws – the proverbial ass, pursue, perpetually, the carrot of the moral ideal.

Homosexuality has an ancient history in India. Ancient texts like Rig-Veda which dates back around 1500 BC and sculptures and vestiges depict sexual acts between women as revelations of a feminine world where sexuality was based on pleasure and fertility [(1)]. The description of homosexual acts in the Kamasutra, the Harems of young boys kept by Muslim Nawabs and Hindu Aristocrats, male homosexuality in the Medieval Muslim history, evidences of sodomy in the Tantric rituals are some historical evidences of same-sex relationships [(2)].

However, these experiences started losing their significance with the advent of Vedic Brahmanism and, later on, of British Colonialism. Giti claims that Aryan invasion dating to 1500 B.C began to suppress homosexuality through the emerging dominance of patriarchy [(3)]. In the Manusmriti there are references to punishments like loss of caste, heavy monetary fines and strokes of the whip for gay and lesbian behaviour. In the case of married women, it is mentioned that 'luring of maids' is to be punished by shaving the women bald, cutting off two fingers and then parading her on a donkey. Manu's specifications of more severe punishments for married women can suggest either a wide prevalence of such relationships among married women or a greater acceptance of these practices among unmarried women In either cases, these references point to the tensions in the norms of compulsory heterosexuality prescribed by Brahmanical partite.

Both sexual systems coexisted, despite fluctuations in relative repression and freedom, until British Colonialism when the destruction of images of homosexual expression and sexual expression in general became more systematic and blatant. The homophobic and Victorian puritanical values regarded the display of explicit sexual images as 'pornographic and evil'. The Western view, since the time of Colonial expansion, has been strongly influenced by reproductive assumption about sexuality These puritanical values and attitudes were in turn mapped into the interpretation of sexual activity among colonial people which is evident from the responses to all forms of 'unnatural' sexual practices. The Indian psyche accepted the Western 'moral and psychological' idea of sexuality being 'pathological' rather than the natural expression of desire, which once used to be part of Indian culture.

The last century witnessed major changes in the conception of homosexuality. Since 1974, homosexuality ceased to be considered an abnormal behaviour and was removed from the

classification of mental disorder. It was also de-criminalised in different countries. Since then various states across the globe enacted anti-discriminatory or equal opportunity laws and policies to protect the rights of gays and lesbians. In 1994, South Africa became the first nation to constitutionally safeguard the rights of lesbians and gays. Canada, France, Luxembourg, Holland, Slovenia, Spain, Norway, Denmark, Sweden and New Zealand also have similar laws. In 1996, the US Supreme Court ordered that no state could pass legislation that discriminated against homosexuals. In India, so far no such progressive changes have taken place and the homosexuals remain victims of violence in different forms supported by the state and society. This paper attempts to see how the state through the legal machinery violates the rights of homosexual people.

Is homosexuality a crime?

A frequently asked question is whether homosexuality is a crime or not in India. An affirmation would be the most frequent answer. How does the Indian laws view homosexuality?

There is no explicit mention of homosexuality or homophilia [(4)] in any of the statute books of India. A person cannot be prosecuted for being a homosexual or homophilic. But the sexual act of sodomy is a criminal offence. The major provisions of criminalisation of same-sex acts if found in the Section 377 of the Indian Penal Code (IPC) of 1860.

Section 377 of IPC reads, "*of unnatural Offences: Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life or imprisonment of either description for a term which may extend to 10 years and shall also be liable to fine*".

Explanation: Penetration is sufficient to constitute carnal intercourse necessary of the offence described in this section"

What does this non-bailable and cognisable offence imply? It is based on the centuries old misconception that sodomy and homosexuality is one and the same thing. A homosexual man is viewed as a 'type of person' who has only anal intercourse with his partner. However the emotional attachments, fantasies and affectionate and erotic desire are not been given due consideration. Thus, de jure, it is an attempt to criminalise sodomy while de facto it is an attempt to criminalise and stigmatise homosexuality. Hence conventionally homosexuality is bought as an offence under the IPC.

In the history of the statute from, 1860 in 1992 there was only 30 cases in the High Courts and Supreme Court [(5)]. The small number of cases filed under this section shows that this section is redundant and outdated and needs to be repealed.

This section raises interesting questions like what is 'natural'? What is the 'order of nature'? "Nature' conceived by whom? And 'Order' perceived by whom? Even if one assumes that the 'order of nature' is penile-vaginal intercourse between a man and woman, Sec 377 remains ambiguous about which sexual acts it seeks to prescribe. For some reason, sodomy between males and male and female and bestiality has been considered 'carnal intercourse' against the order of nature. But there is no reported judgements of the High Courts or the Supreme Court declaring that cunnilingus or fellatio would consider an offence punishable under Sec. 377 of IPC.

Even though this section does not distinguish sodomy between males and between male and female, this section is targeted against males more so than females. In 1992, 18 men were arrested from a park in New Delhi on the suspicion that they were homosexuals. After protest and demonstration by gays, lesbians and human rights groups, they were released from police custody after filing a petty case against them. In fact they were not indicted under Sec. 377 but under the provision of public nuisance under the Delhi Police Act. There are similar sections in the Police Acts of different states of India. This section is used by the police and heterosexuals to blackmail gay men and other men who have sex with men and to extort money and valuables from them. This more so happens in parks, certain streets and public toilets, which function as an informal sexual networking area for homosexual men.

This section has been used to intimidate women, particularly in the case of women who have run away together or if they make their relationship known. In 1987, Tarulata/Tarun Kumar underwent a female to male sex change operation and married Lila in 1989. Lila's father filed a petition in the Gujarat High Court saying that it is a lesbian relationship and that the marriage be annulled. The petition contends that 'Tarun Kumar possesses neither the male organ nor any natural mechanism of cohabitation, sexual intercourse and procreation of children'. Adoption of any unnatural mechanisms does not create manhood and as such Tarun Kumar is not a male. The petition called for criminal action under Sec. 377 and the case is now pending in Gujarat High Court.

No distinction is been made between consensual and coercive sex. From 1860 to 1992, out of the 30 cases, 18 were non-consensual, 4 were consensual of which 3 were before 1940 and 8 were unspecified. In a judgement (Fazal Rab Vs State of Bihar) the Supreme Court was dealing with a case where a man had homosexual relations with a boy with the consent of the boy. The Supreme Court in 1983 observed that: 'the offence is one under Sec. 377, IPC which implies sexual perversity. No force appears to have been used... neither omissions of permissive society nor the fact that in some countries homosexuality has ceased to be an offence, has influenced our thinking'. Considering the consent of the boy, the Supreme Court reduced the sentence from 3 years rigorous imprisonment to six months rigorous imprisonment. Under this clause, a third party can sue the partners who voluntarily entered into sodomy thereby infringing on the right to personal liberty and privacy as enshrined in the Fundamental Rights of the Constitution.

Heterosexual couples engaged in sodomy can also be indicted under this section. Marriage is taken as an implied consent by the wife for 'normal' intercourse and not for anal intercourse. If the wife consented, both are guilty, if she did not, the husband alone is guilty. Under Sec. 13 of the Hindu Marriage Act, 1855 and Sec. 11 of Indian Divorce Act, 1869 a wife can apply for divorce if the husband has been guilty of sodomy/bestiality.

This section (377) is mostly been used to register cases on the child sexual abuse, since the rape laws do not have scope to include male rape. On the other hand 'Against the order of nature' is broad enough to include sexual abuse of male children. During the period of 1860 to 1992, 15 out of 30 cases registered were assault on minors.

Constitution and other provisions

The Indian Constitution states that 'there shall be no discrimination on the basis of the sex of a person' which is a Fundamental Right of the citizens. The term 'sex' although refers to the biological sex of a person as male or female, is broad enough to include sexual orientation also in the present context.

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Section 292 of IPC refers to obscenity and there is ample scope to include homosexuality under this section. Last year a parcel containing a few copies of a gay and lesbian magazines for the South Asians from the US sent to a gay group in Calcutta for distribution of subscribers was confiscated by the Customs authority. They contended that as per law this publication amounts to obscenity and offensive to the morality of the country. This case was closed when the addressee discarded the parcel seeing no way out.

The concept of family refers to a universal, permanent and pervasive institution characterised by socially approved sexual access and reproduction, common residence, domestic services and economic co-operation. Let me quote two instances of alternate marriage system as existing in India. Amongst the Nayar community in South India, who followed the matrilineal system of descent, several men could have access to a woman through the *Tali* rites and subsequent Sambandham unions. The *Tali* chain and locket worn around the neck was tied by a man of appropriate ritual status on behalf of his sub-caste collectively, which acquired sexual rights over the woman concerned. These rights were extended to any member of the higher caste usually Nambudiri who was attracted to and was found acceptable for the woman.

Men who had Sambandham relations did not have any exclusive rights as husband or as father; the woman could withdraw the sexual access allowed to them at any time if she so wished. The right over her progeny was vested in her Tarawad (household of matrilineal kin). In the Nayar-Nambudiri Sambandham, the latter could not ever dine with his wife or children, not to speak of sharing any domestic chores or economic activity.

In a small village Angaar in Gujarat, among the Kutchi community a ritualistic transgender marriage is performed during the time of Holi festival. This wedding which is being celebrated every year, for the past 150 years is unusual because Ishaak, the bridegroom and Ishakali the bride are both men.

Inspite of the existence of alternative marriage systems and customs, the conventional definition of a family includes a man and a woman along with their resultant children. This definition is based on the notion of compulsory heterosexuality and homophobia. There is no legislation at present in India where same-sex couples could register as domestic partnership or civic contract unions.

Under the labour laws, the provision under 'moral turpitude' is anti-homosexual. Mere claim of an employee is enough for dismissal from the job. A relationship not based on blood or marriage is not entitled for Social Security benefits under Employee Provident Fund Act, Pension Act, Workmen Compensation Act, Insurance Act, Housing Act etc.

The legal status of homosexuality in the Indian Armed Forces follows the model set by Sec. 377 of IPC. Sec. 46 of chapter VI – offences of the Army Act, 1950 states: any person subject to this Act who is guilty of any disgraceful conduct of a crude, indecent or unnatural kind shall on conviction by court-martial, be liable to suffer imprisonment for a term which may extend to seven years or much less punishments as is this Act mentioned Similar provisions exists in the Air force Act and Navy Act.

Legal remedy

In 1994, a controversy emerged when a medical team visited the Tihar jail in Delhi and reported a high incidence of sodomy in the male wards. They recommended making provisions

for condoms, as there was a risk of HIV infection being transmitted into the jail inmates. The jail authorities abstained from making provisions for condoms since it will mean that they are approving a crime and aiding and abetting an offence under the IPC.

A human rights activist group ABVA filed a Public Interest Litigation in the Delhi High Court. The petition challenges the constitutional validity of Sec. 377 of IPC and advocates supply of condoms to jail inmates, with a plea to restrain the authorities from segregating or isolating prisoners with homosexual orientations or those suffering from HIV/AIDS.

The petition urges that Sec. 377 is obsolete and must be struck down as being unconstitutional on the grounds that Right for Privacy is part and parcel of the Fundamental Rights of life and liberty under Article 21 of the constitution and recognised by the 1948 International Convention on Human Rights; Sec. 377 is a violation of Article 14 of the constitution since it discriminates persons on the basis of their sexual orientation; having been enacted in 1860, Sec. 377 is archaic, absurd and implemented by the British in all its colonies, including India, but now been repealed in England, the country of origin.

The initial response of the judges during hearing of the petition was quite homophobic. They questioned whether the petitioner wanted to promote 'free-sex and pervasive sex'. When a senior advocate appeared for the petitioner, the judges quickly changed their attitude and heard the petition with sympathy. This case is also pending for argument in the court.

This is the only case, which has been filed against anti-discriminatory homosexual laws in India. The point of argument in this case is more from a sexual health perspective and less from the gay right perspective. Seeing the Indian socio-cultural and political situation, gays and lesbians will take more time to come forward to fight for their rights. However an increasing number of gay groups through out the country and serious thinking among them is seen in India in the last few years.

We know that the law enacted in any country is often the product of majoritarian popular consenses. Some of the laws reflect the prejudices and myths of existing societies and thus try to marginalise some minority groups like homosexuals. Shouldn't the law help counter the prejudices and silencing and protest the rights of the marginalised section?

Notes

1. 'Giti Thadani - Independent lesbian researcher'. Interview with Lesbia magazine reprinted in Shakti Khabar, Issue 14,1991.
2. Joseph Sherry: 'Emerging gay movement in India: a liberal- conservative movement' in Balachandran and Baalagaopal (ed): The Indian Closet : 'In' and 'Out', University of Illinois Press, USA, (forthcoming)
3. Ibid
4. Homophilia emphasis love (philia) instead of only sexual behaviour. It focuses on affectionate and erotic desire instead of viewing homosexuals as 'certain kind of people'
5. Khanna Shamona: 'Gay Rights', The Lawyers, June 1992.

CEHAT, Mumbai, India

Paper: 23

Promoting violence in the name of protection

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Sex work as an occupation puts the sex workers at significant risk of personal violence from clients, from persons in economic control of the trade, and at times from police and persons in authority on grounds of enforcement of law. Children of sex workers and minors in the sex industry also run the risk of physical and emotional abuse because of the environment in which they are brought up and due to the stigma attached to the community. Systematic attempts of protection of sex workers from violence by police, those in authority, NGOs, researchers etc. have proved futile in most of the cases. On the contrary, it seems that their efforts towards protection from violence adds to promote violence.

Here we can group these efforts in 3 categories:

Preventing minors from entering into the trade

With an apparent intention of preventing the minors from entering into the sex trade, the police officials conduct raids in the red light areas, pick up both majors and minors and put them in the lock up. Once a woman - major or minor, enters into this profession or somehow gets involved in the sex trade, she is accepted back neither by her relatives nor by the society; norms of which are designed by the people of the upper echelons of society. Since these women generally belong to the lower socio-economic strata of the society, their relatives do not have the economic, political or moral strength to fight with the society. And the social taboos and stigma attached to this profession creates an environment that miserably fails to unite these girls again with their families. Investigations were made in several cases (about a dozen) in the recent past where police after arresting the minors put them in the custody and through judicial proceedings they land up in the designated remand homes, living conditions of which are even worse than the red light areas, and ultimately the minors find no other alternative but to resettle back to the red light areas which they have left, thereby completing a full circle. The amount of humiliation, mistreatment and torture they receive in the process is unbelievable. In fact the "exercise of violence" meted out to them - (social, familial or otherwise) that forces them to enter into this profession is being strengthened by the same societal process of "rescuing and rehabilitation" designed by another category of "actors" through state patronage who probably share the common values - values of disrespect and to derecognise the rights of individual from the point of their awful power and position. In the process it is not only the minors, but majors are also treated in the same manner just to remind them that they have no moral right to enjoy the basic human rights and dignity. Several non Govt. organisations have shown keen interest to get involved into this "rescuing" operation in collaboration with police authorities having little or no knowledge about the structure and function of sex trade scenario and its inner contradiction. But in the process they subserve the interest of another group of exploiters and their actions strengthen the state mediated violence which in turn justify the social culture of dichotomy and the rule of patriarchal society. But in the recent past, sex workers' effort to organise themselves and their struggle against the oppressors and exploiters, their demands for a Self Regulatory Board, repeal of the offensive act - Immoral Traffic Prevention Act,

recognition of sex trade as a profession etc. has found to percolate within the society which has been observed in the opinion poll conducted during the Calcutta book fair -98 where the book fair attendees were found to be aware of the sex workers' organisation.

The opinion poll was conducted amongst a sample of 525 persons, out of which 78.7% were males and 21.3% were females. 66.10% of the male respondents belonged to the age group of 20-40 years, followed by above 40 age group. Similar trend of age group was observed among the female respondents. Regarding educational status, it was found that 39.62% of respondents were graduates and 26.7% were technically qualified persons. Regarding occupational status, majority of the service holders (31.4%) were interviewed followed by the professionals like doctors, lawyers, engineers, journalists (21.9%) which was followed by students (18.1%) and businessmen (15.8%).

When asked that if they had any idea about the nature of torture the sex workers have to face, only 54.7% of the respondents expressed that they knew about it but at the same time about 77% of the respondents expressed their eagerness to know more about the sex workers. Regarding the reasons behind the clients coming to the sex workers, 60.38% of the respondents believed that physical urge is the main reason, 42.85% of the respondents said that mental and physical urge is the reason and 40.38% said that it is the curiosity of men that brings them to the sex workers.

On query about the reasons of police raid, 72.76% of respondents said that the police conducts raids primarily to earn money and only 17.7% believes that police conducts raids to nab *goondas* and anti-socials.

When asked that if they have heard about the sex workers' organisation, 74.7% of the respondents knew about the SWs organisation, 70.72% expressed their positive attitude towards sex workers and 57.21% expressed their willingness to help the sex workers.

Preventing HIV transmission through research

In early 1996, a NGO in Central Calcutta experimented with unqualified AIDS vaccine on the hapless sex workers without any permission from the Govt. thus diluting any demarcation between the experimental creatures kept in laboratory and the sex workers. This may be an extreme case, but as a rule rather than an exception, researchers carry out studies on HIV sero-surveillance and behavioural practices of sex workers without fulfilling ethical guidelines, and at times use force and even resort to physical coercion with an "objective to contain the spread of STDs & HIV/ AIDS" among the sex workers. The researchers in their zeal, hardly consider the basic rights of an individual and established policies of ethical review process, as the studied population is the sex workers - who, in their eyes, do not qualify as human beings with rights and dignity. In most of the circumstances, the media and the academia either prefer to keep silent or support the process overtly or covertly.

Evicting sex workers to prevent growth of sex trade

Some segment of the society view sex work from moral point of view and believe in the approach of abolition of the red light areas and rehabilitation of sex workers as effective measures to prevent the growth of sex trade. During the era of AIDS control, it has become the endeavour of some vested interest groups who in collusion with powerful lobbies and real estate agents with tacit support from the Govt. authorities, try to manipulate people's sentiment and exploit the moral stance of society to throw the sex workers out of their homes and evict

the red light areas thus depriving the sex workers of their livelihood. In all these instances, it has been observed that government policies and written code of conduct has hardly helped to protect the rights and livelihood of these under privileged section of the society.

Lessons learnt

The perpetual violence within the sex trade settings cannot be altered or individual sex worker cannot be protected from the onslaught of violence provided her social and legal status and her working environment gets transformed. The basics of vulnerability as defined by her powerlessness within and outside the trade, the sitgma and the moral value attached to the profession and the historical bondage which predetermines her status and position makes her vulnerable to the traditional social exploitation. It is also true of any newly designed programme meant to support the sex workers as the planners decide and plan based on their social values and concepts without considering the sex workers perception of the sex profession.

Once in the profession, the sex workers have continued to remain so for various reasons. The most prominent reason is the social ostracization of sex workers, which does not allow her to live with dignity wherever she chooses to live in and opt for some other occupation for her survival. So, a sex worker cannot be truly "rescued and rehabilitated" and forcing her to take up some other profession which she does not want to, will be a violation of her human rights and her right to self-determination.

It can only be done through empowerment of sex workers not only at the individual level but also at the societal and community level through active participation of the sex workers' community

This issue has neither been addressed by social workers or by human right protagonists. It is more likely that the "social exclusion process" that prevents the sex workers from taking part in social and political arena also blinds the vision of human rights groups from looking into their issues. This exclusion process also holds back the sex workers, the most marginalised group of women of society, from raising their voices against violence and decide their own destiny.

CEHAT, Mumbai, India

Paper: 24

Primary health care Responsibility of state agencies

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I would like to present my views on violence by stage agencies with reference to primary health care in India. As all of you are aware, Primary Health care aims at providing a comprehensive health service involving promotive, preventive and rehabilitation services as opposed to curative services available at present. **It is the primary responsibility of the state to provide for such a health service by proper planning, execution and co-ordination of the activities of its various organs or agencies.**

The Constitution of India provides that such a health service is the responsibility of the state. The relevant provisions are in the Directive principles of state policy. They are extracted here under.

"The State shall, in particular, direct the policy towards securing, that the health and strength of workers, men and women and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength. That childhood and youth are protected against exploitation and against moral and material abandonment. The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want. The State shall make provision for securing just and humane conditions of work and maternity relief. The State shall regard the raising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties".

Consistent with the resolution of W.H.O. Assembly of May 1977 to provide *"Health for all by the year 2000"*, the parliament approved the National Health Policy in 1983 reaffirming its commitment to the goal of health for all by the year 2000. Despite its efforts the Government agencies fell far behind its objective in establishing a primary health care service, which in turn is a violation of its own commitment. And thus we today discuss the status of Primary Health Care, as under.

Primary health care: Responsibility of state agencies
"Man to exist there should be life
Life to live there should be health
Health to prevail, there should be health wisdom."

Health is wealth is the saying. It is viewed as absence of disease. If an individual is free from disease he is considered to be healthy. He is considered to be wealthy also. It is difficult to define the word "Health," Webster's dictionary defines it as: The condition of being sound in body, mind or spirit especially freedom from physical disease of pain. Oxford English

dictionary defined it as "Soundness of body or mind; that condition in which its functions are duly and effectively discharged."

In the preamble to the constitution of World Health Organisation it is stated that, health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity and ability to lead a socially and economically productive life.

The primary responsibility of earning or maintaining health is on the individual and it is termed as self care. Levin defines it thus: Self-care is a process by which people function on their own behalf in health promotion and prevention and disease detection and treatment at the level of primary health resources in the health care system.

According to John Fry, self-care envisages:
Health maintenance and disease prevention, Self diagnosis, Self medication, Self treatment and Patient participation in professional care (Use of services)

The self-care actively comprises of observance of simple rules of behaviour relating to diet, sleep, exercise, w eight, alcohol, smoking and drugs. Attention to personal hygiene, cultivation of healthful habits and life styles, reporting early when sick and accepting treatment, undertaking measures for the prevention of a relapse or of the spread disease, family planning etc., are some of the other measures to be taken by the individual to keep himself healthy. Self care is not a fool proof method. It has limitations. It may weaken client trust professional care. It is not a substitute for professional care. These limitations could be overcome if the self-help groups could be a part of professional care and if doctors act as consultants to self help groups. If these self care groups are encouraged, the demand for beds in the hospital will be minimised thereby making the professional skill available to secondary care. In view of the limitations referred to above and for other reasons the individual cannot solve his health problems without the total participation of the community to which he belongs.

Community involvement in health care: Involvement and participation of the people of the rural areas is one of the most important component in development of human resources – the rural man himself – acts as a promoter in health communications strategy at all levels. The community can participate in the health care in the following ways:

It can provide in the shape of facilities, manpower, logistic support and funds
It can be actively involved in planning, management and evaluation
It can involve itself by joining in and using the health services.

It is, however, not easy to obtain the involvement of the community in the health care services for various reasons.

Responsibility of the state agencies
To take care of an individual health, two streams of health care infrastructure are employed. Of these the public health wing is the more important. Public health includes measures for the prevention of infectious disease. This is to be provided by the state and its various agencies like the municipality Inefficient functioning of public health establishments is ruinous to the health of the individuals and the society.

It is to be noted that 10 per cent of the health in the society is dependent on Doctors medicines and hospitals. Ninety per cent of the health relates to life style (smoking, diet and nourishment, exercise mental status) social and financial state, environment (clean air and water) and

measures for providing public health. This vast segment, over which the medical profession has no control, is responsible for most disease and deficiencies. Health departments should not be allowed to provide only medical care.

After three decades of trial and error and dissatisfaction in meeting people's basic health needs, the World Assembly in May'97 decided that the main social goal of governments and World Health Organisation in the coming years should by the attainment of a level of health that will permit them to lead a socially and economically productive life. The goal is popularly knows as 'health for all by the year 2000'. This does not mean that in the year 2000, doctors and nurses will provide medical care for everybody in the world for all their existing ailments or does it mean that in the year 2000 nobody will be sick or disabled. It means that there will be an even distribution among the population of what ever resources for health are available so that people will use available approaches for better health.

The Alma Ata, USSR conference on primary health care re-affirmed in 1978 health for all as the major goal of governments and stated that the best approach to achieve the said goal is by providing primary health care especially to the under-served rural people and urban poor. India is a signatory to the Alma Ata Conference. The National health policy approved by parliament in 1983 clearly indicates India's commitment to the "good health for all by the year 2000". The policy lays stress on the preventive, promotive, public health and rehabilitation aspects of health care and points out the need of establishing comprehensive primary health care services to reach the population in the remotest areas of the country.

Health care services are usually organised at three levels, each level supported by a higher level to which the patient is referred These levels are: (1) Primary health care (2) Secondary health care (3) Tertiary health care

Primary Health care: This is the first level of contact between the individual and the health system where "essential" health care (Primary Health Care) is provided. A majority or prevailing health complaints and problems can be satisfactorily dealt with at this level This level of care is closest to the people. Primary health care is defined by W.H.O. as **an essential health care made universally accessible** to individuals and families in the community be means acceptable to them through their full participation and at a cost the country can afford."

Primary Health Centre

The Bhore committee in 1946 gave the concept of a primary health centre as a basic health unit to provide, as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The Central council of Health at its first meeting held in January 1953 had recommended the establishment of primary health centres in community development blocks to provide comprehensive health care to the rural population. The number of primary health centres established since then had increased from 725 during the first five year plan to 5488 by the end of fifth plan (1975 - 80), each Primary Health Centre covering a population of 1,00,000 or more spread over some 100 villages in each community development block.

The Mudaliar committee in 1982 has recommended that the existing primary health centres should be strengthened and the population to be served by then to be scaled down to 40,000. The National health plan proposed re-organisation of primary health centres on the basis of one Primary health centre for every 30,000 rural population in the plains and one primary health centre for every 20,000 population in hilly, tribal and backward areas for more effective coverage. At the end of June 1996, 21,859 primary health centres were established in the

country as against the total requirement of about 23,000. These centres were functioning as peripheral health service institutions with little or no community involvement.

It may be stated that these centres were not able to provide adequate health coverage partly because they were poorly staffed and equipped and partly because they had to cover a large population to one lack or more. At present in each community block, there are one or more Primary Health Centres, each of which covers 30,000 rural population. It is expected to equip the primary health centres with facilities for selected surgical procedures namely vasectomy, tubectomy, MTP and minor surgical procedures and for paediatric care.

The Primary health care aims at: (1) Equitable distribution (2) Community participation (3) Inter sectoral co-ordination (4) Appropriate technology (5) Health Education

Equitable Distribution: The first key principle in the Primary Health care strategy is equitable distribution of health service, that is, the health services must be shared equally by all people irrespective of their ability to pay and all, rich or poor, urban or rural, must have access to health services. At present, health services are mainly concentrated in the major towns and cities resulting in inequality of care to the people in rural areas. The worst hit, are the needy and vulnerable groups of the population in rural areas and urban slums. This is social injustice. The failure to reach the majority of the people is usually due to inaccessibility Primary health care aims to redress this imbalance, by shifting the centre of gravity of the health care system from cities where three quarters of the health budget is spent, to the rural areas where three quarters of the people live and bring these services as near people's homes as possible.

Community participation: The involvement of individuals, families and community in promotion of their own health and welfare is an essential ingredient of primary health care. Health guides and trained dais are an essential feature of primary health care in India. Village Panchayats also involved in the maintenance of Public Health and Sanitation.

Inter Sectoral co-ordination: Primary Health Care involves in addition to the health sector, all related sectors and aspects of national and community development in particular, agriculture, animal husbandry, food, industry education, housing, public works, communication and other sectors. All National Health Programs are also expected to be implemented.

Appropriate technology: Technology that is scientifically sound and acceptable to local needs and acceptable to those who apply it and those for whom it is used. The technology that can be maintained by people themselves in keeping with the principle of self-reliance with the resources the community and country can afford.

The following are the eight essential components of primary health care.

1. Education concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supply and proper nutrition.
3. An adequate supply of safe drinking water and basic sanitation.
4. Maternal and child health-care, including family planning.
5. Immunisation against major infectious diseases.
6. Prevention and control of locally epidemic diseases
7. Appropriate treatment of common diseases and injuries
8. Provision of essential drugs

In the context of the size of the population the socio-economic development and the existing health status of the people, the National Health policy in India has the following notable elements.

- A greater awareness of health problems and means to solve them in and by the communities.
- Supply of safe drinking water and basic sanitation using technologies that the people can afford.
- Reduction of existing imbalance in health services by concentrating on the rural health infrastructure
- Establishment of a dynamic health management information system to support health planning, and health programs implementation
- Provision of legislative support to health protection and promotion
- Concerted action to combat widespread malnutrition
- Research into alternative methods of health care delivery and low-cost health techniques, and
- Greater co-ordination of different systems of medicine. In order to achieve the said objectives, the health policy laid down the following goals to be achieved by the year 2000.

	Indicator by 2000	**Current level**	**Goal to be achieved**
1.	Infant mortality rate	73 (1993)	Below 60
2.	Prenatal mortality rate	44.2 (1993)	30 - 35
3.	Crude death rate	9.2 (1994)	9.00
4.	Under 5 mortality rate	23.7 (1993)	10
5.	Maternal mortality rate	4 (1993)	Below 2
6.	Life expectancy at birth		
	Male	60 (1993)	64
	Females	61 (1993)	64
7.	Crude birth rate	28.6 (1994)	21.0
8.	Net reproduction rate	1.5 (1990)	1.0
9.	Couple protection rate	43.5% (1993)	60
10.	Annual growth rate	2.1 (1996)	1.20
11.	Family size	4.0 (1998)	2.3
12.	Babies with weight		
	Below 2500 gm %	30	10
13.	Immunisation		
	TT coverage for pregnant women (%)		
	DPT	76.41	100
	Polio	76.82	85
	BCG	83.69	85

In addition to the above, the data below indicate the current status and the future projections.

Population :	1986 – 762 million 1996 – 923 million

Birth Rates:
1986 – 91 -- 30.9 per 1000 population
1991 – 96 -- 27.5 per 1000 population
1996 – 2001 – 24.9 (Expected) per 1000 population

Death Rates:
1986 – 91 -- 10.8 per 1000 population
1991 – 96 -- 9.4 per 1000 population
1996 – 2001 – 8.4 per 1000 population

General Fertility Rates:
1986 – 91 -- 141 per 1000 population
1991 – 96 -- 123 per 1000 population
1996 – 2001 – 109 per 1000 population

Crude Death Rate (1991):
Rural - 10.6 per 1000 population
Urban - 7.1 per 1000 population
Combined - 9.8 per 1000 population

Infant Mortality Rate (1991):
Rural - 87 per 1000 population
Urban - 53 per 1000 population
Combined - 80 per 1000 population

Peri Natal Mortality Rate
Rural - 49.1 per 1000 population
Urban - 32.7 per 1000 population
Combined - 46.0 per 1000 population

Source: Sample Registration System, Registrar General of India

Per Capita (Public Sector) Expenditure on Health and Family Welfare (Medical and Public Health, including water supply and sanitation during 1985 – 86 to 1989 – 90)

	1986 - 87	*1987 - 88*	*1988 - 89*	*1989 – 90*
Health	Rs. 54.57	Rs. 60.61	Rs. 65.98	Rs. 69.85
Family	Rs. 7.61	Rs. 8.17	Rs. 8.00	Rs. 13.18

Source: *The Expenditure figures on Medical, Public Health and Family Welfare obtained from the Comptroller and Auditor General of India.*

Nurses registered with Medical council of India 1992– 45 per1 lakh population

1993	
Nurses (Diploma certificate holder)	10908
Midwives	64022
Auxiliary Nurse Midwives (female health workers)	8401
Health Visitors	470

Source: *Indian Nursing Council*

Doctors Registered with Medical Council of India – **410800**
Doctors registered with State Medical council – (1992) – **4,10,875**
Government Doctors – **39466** (in the year 1991)
Source: *Medical Council of India*

	Post Sanctioned	*Persons Available*	*Post Vacant*
Surgeon	930	657	273
Obstetrics & Gynaecologist	611	359	252
Physicians	528	404	124
Paediatrician	490	272	218
Specialists	3562	2471	1091

Doctors (Medical Officers) at Primary Health Care:

Posts sanctioned	Persons available	Posts Vacant
27539	23490	4053

Source: *Rural Health Statistics.*

Despite its universal application it is generally misunderstood that primary health care is confined to rural areas. Access to primary health care is not prerogative of the rural community and urban slum areas alone. It is an essential need of every individual in urban areas also. The importance of the primary health care is not properly understood by the people in rural areas because probably of illiteracy, poverty and backwardness etc., only the planned programs like immunisation, environment activities take place in P.H.Cs with little or no impact on the minds of the people. While poverty and helplessness of the vast majority manifest in rural areas, opulence, concentration of human and medical achievements are exhibited in the urban areas privileged only for a few minority. In urban areas the chief deliverer of public health services are Municipal Corporations, individual and group practitioners in general, special and super special branches and above all hospitals both Government and private displaying the best form of modern medicine, also provide Health Care Systems. The contribution of modern medicine in diagnosis, emergency management and surgical repairs is unique and perhaps yet to find an alternative for this branch of medical service. At present our hospitals are flooded with the sick and we are yet to find an institution which otherwise engaged in cure and therapy to share the people to promote health and prevent diseases with equal importance of therapy. Primary Health Care, not only aims at freeing the individual from the disease but also promote his physical, mental and social well being and enable him to use his potentials to the maximum capacity, useful for himself and his fellowmen, with the ultimate objective to find for himself in comfort, content, happiness and peace. At present there is no proper system or procedure for the accountability of health care institutions. There is no accountability so far as quality of medical care is concerned. No consideration has so far been given to institutional effectiveness in the health care delivery system from the viewpoint of community or larger society. In spite of putting high priority on health care by the national planners the proportionate increase in allocation of resources to primary care is yet to take place.

While there is a need for a general practitioner there is an unhealthy tendency now a days, to put a specialist in his place. A serious imbalance has already been created in many parts of the country by neglecting primary care in favour of specialised medicine by attaching more importance to diagnosis as opposed to therapy by spending huge sums on individual medical treatment like transplant at the cost of preventive and promotive care. Community health and the health of the individual are of equal importance and the range of medical services available for the individual care reflects the need of the community Preventive medicine and rehabilitation medicine is to be given proper consideration in relation to curative medicine.

The following are the obstacles for the Primary Health centres.

- Lack of roads, transport system and communication links.
- Lack of electrification
- Lack of basic needs of food, clothing, and shelter

- Multiplicity of agencies giving overlapping services
- Professional Resistance by practitioners in different systems of medicine. They feel it as a threat to their future. Their participation and understanding is a must.

Secondary Health Care: At this level more complex problems are dealt with. This care comprises essentially curative services and provided by the district hospitals and community health centres. This level of service is the first referral level in health system.

Tertiary Health Care: This level offers super specialist care. This care is provided by the regional/ central level institutions. It envisages not only highly specialised care but also planning and managerial skills and teaching for specialised staff. In addition, the tertiary level supports and compliments the action carried at the primary level.

As envisaged earlier Health education, adequate food, safe and adequate drinking water, care of mothers and children, immunisation, prevention and control of local endemic diseases, treatment of common diseases and injuries and provision of essential drugs are the elements of primary health care.

Unless all these elements are adequately and continuously provided, Primary Health Care has no meaning. It is astonishing to note that the performance of government in providing adequate primary health care to the people is not satisfactory.

In rural areas, majority of the people is ignorant about the causes of the various diseases, the methods of control and to prevent them. They do not have even the basic necessities like proper food, clothing and shelter. Which a bearing on their health. They are unable even to approach the doctor due to various reasons. It is necessary to educate them so that they may lead a happy and peaceful life.

The situation is no better in urban areas also. It is significant to note that at present there is effective system at all or primary health care in urban areas. The people have no access to primary health care. Even for minor ailments. The government agencies are filled to provide adequate primary health care facility round the clock. To sight an example, I have to know from my friend who lives in Hyderabad that no doctor was available to him at 1.30pm to confirm whether her mother who suddenly fell down and became unconscious was dead or alive. If only a primary health care facility was available he would not have faced such a dilemma. This is nothing but denial of primary health care to the people.

The Primary Health care system also aims at bringing health care to the door step of the family by providing promotive, preventive, curative and rehabilitative services. It must act as a family physician of yesteryear.

Who is responsible for this state of affairs? The Government is primarily responsible for the existing health status in our country. The Government, the society and the medical profession are responsible for improving the health status of the people.

It is the primary duty of the state to improve public health. The people have therefore a right to proper health care. If the people have no access to the basic health care it amounts to violation of the rights vested in the people. The state is therefore responsible for the injury caused to the people thereby.

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Paper: 25

Problems faced in treatment and rehabilitation Of mentally disturbed destitute women

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Rehabilitation is one of the most difficult areas of work with regard to mentally ill persons. The reasons for this are as follows:

They are not fully in touch with the real world. They are constantly oscillating between the so-called real world and a world of their own. As a result, it is difficult to identify which part of their conversation is rooted in our reality and which is coming from a world of their own.

Our experience shows that if decisions are taken on behalf of the person, without taking her into confidence, it usually backfires. At the same time, it is extremely difficult to completely go by what such a person says. Therefore, a delicate balance has to be struck between client participation in decision making and acting on behalf of the person in her interest.

The medical profession generally does not allow much scope for participation of the patient in the treatment process. This is opposed to the ethics of the social work profession, thus creating a conflict of perspectives between them.

Women's institutions and hospital authorities are generally reluctant to admit such persons into their homes/hospitals. Families are difficult to trace and not very forthcoming in supporting such persons, if traced.

Every lead should be taken seriously and followed up. For this, there has to be mutual sharing of information and proper co-ordination between the hospital authorities, the social work agency, the police, the family and any other NGO/Govt. agency involved in the process of rehabilitation.

Because of all the above reasons, most people do not feel it is possible to rehabilitate them at all. But our experience has shown that it is possible, provided, we are patient, persevering, explore every available option and do not give up hope.

Role of the police: The police has a crucial role to play in the rehabilitation process of mentally ill persons. As per the ***Mental Health Act***, any person found without care or support, seemingly mentally ill and, in the opinion of the police, likely to cause injury or harm to herself or to others, can be taken charge of and produced before a magistrate (or the Commissioner of Police or his deputy) to be sent for treatment in a psychiatric hospital or nursing home.

Any person or agency can take the help of the police in getting a mentally ill person admitted to a hospital for treatment. This can be done by producing the person before police or by informing them about whereabouts of the said person for suitable action to be taken. Police help can be taken by the hospital authorities by asking for an escort for the patient while the patient is undergoing treatment as an inpatient. This is particularly useful when the patient concerned is

without family support and the hospital authorities feel the need for an escort with the patient round the clock.

Police help can also be taken in the efforts to trace the family of the mentally ill person. This can be done after sufficient details have been gathered about the whereabouts of the family. If the family resides outside the city or the state, then the police can take the help of their counterparts in that area.

Alternatively, one could directly get in touch with the police of the area concerned and request for their help in tracing the family of the person.

Lastly, police help may be required to escort the person to her native place, the residence of some relative or friend who is willing to take responsibility for her, or some women's institution (government or NGO) willing to admit her as an inmate and take responsibility for her rehabilitation.

Conclusion

The attempt in this paper has been to draw insights relevant to the effective rehabilitation of mentally destitute women living on the streets and without supports. That these women may have been subject to physical, mental or sexual violence needs no reiteration. They are also extremely vulnerable to such violent acts in future by virtue of the fact that they live on the streets, are without supports and are mentally unstable. It is imperative that if we are a society, which cares for the weak and the vulnerable, we make efforts to get such persons off the streets. The rationale that it is difficult to rehabilitate them cannot be a justification for not making any efforts in that direction. At the same time, it is not possible for any one agency to take the entire responsibility on itself. Possibilities will open up only when all the concerned agencies work together to achieve the desired goal. If doctors, the police and social work agencies realise that it is possible to work hand in hand to positively intervene with mentally ill women on the streets, then, a small step would have been taken towards the welfare of one of the most neglected and vulnerable sections of our society.

CEHAT, Mumbai, India

Paper: 26

Role of health services in disaster management

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Keyword: disaster – health service – epidemic prevention – medico-legal expert – ancillary services – socio political approach

Disaster is an event which is out of reach, even with best of technological set up, and which has long term after effects in different social & economic aspect. To prevent this event to occur is the best solution but is next to impossible. Research in social sciences and then to other allied areas has developed some methods to foresee such happenings so as to take necessary precautionary action. Even though this helps as a tool to foresee some bad event but it never helps in correcting action for the prevention. Considering this broad background in mind, which has even distribution all over the world, this article is submitted to initiate the process by which disaster can be managed in most social way.

Disaster in most sensible meaning synonyms **casualty of man and machinery**. The breakage of machinery or system can be repaired or replaced by collective efforts of state, centre and professional organisation like Insurance companies. This replacement / repair is many times better than the previous model in not leaving behind any scar. But contrary to this, any smallest effect on HUMAN BEING extending from mental trauma to physical disability & death is irreparable by best of efforts. To minimise this loss, medico-legal expert with practical experience dealing in such situations can be an asset to society & government. The role of such experts in ensuring Health services is categorised as:

Management of treatment facility

Attending those who have survived after this event is most Human way of combating situation. This requires emergency medical care and psychological assurance from State agency so as to boost up the morale. This requires good infrastructure & best utilisation of available information & manpower.

Immediate information from local health authority about existing health facility esp. Number. of Hospitals, number of indoor beds, categorisation of manpower, list of emergency drugs / instruments with number of such available sets etc.

To select the team of Health Professionals &Supporters from local group to analyse the situation and estimate Human loss with type of injuries and / or other disease so as to segregate the treatment modalities.

To prepare a Blue print of the available facts and estimated forecast so as to make a list of need of Manpower in different specialities according to time schedule and the facility available with them like Transport, Drug etc.

To open emergency medical centre at different places especially where these victims have migrated, and to make available indoor beds. These centres should equipped with necessary

instrument, drugs and manpower to provide facility for Counsellor & Medical social worker. The private hospitals Beds can also be utilised for this purpose talking them into confidence.

To provide facility for accommodation and food to all Medical & paramedical staff working for the cause. Also, their services should be time bound and new staff should be appointed according to schedule so as to have better efficiency from the staff.

Management of epidemic prevention

To prevent disease occurrence is as important as treating victims. For this, we can always take help of Epidemiologist & Teaching staff of Preventive & Social Medicine department of any Medical college. The diseases which are to be taken care are very limited like Water Borne diseases, Malaria, Typhoid etc. At times, one has to consider the event so as to project the probable disease which needs to be prevented. Very nominal costs are incurred for this purpose & it requires Health education & support of community. The basics of Cleanliness, Chlorination of water & Judicious usage of Anti Malarials and other specific drugs will serve the purpose. The sanitation is most important tool which will take care of most of this epidemic. For this purpose, Sanitary Inspector with enough subordinate staff should be employed so as to decrease morbidity.

Water borne disease: The supply of drinking water should be controlled by Health Authority. At affected places, it should be made only by water tankers containing about 11,000 liters of water, source of which should be checked for quality. All such tankers should be tested again at common entry point by sanitary inspector and chlorination done by approx. one tablet of chlorine (500 mg) for 50 litres of water.

Food borne disease: The check on supply of food is very difficult as it has some emotional values. All Non-governmental organisations (NGO) working during such calamities gather large quantity of food from different sources & then distribute it. Here, the most common Food Packs are Roti & Potato Veg. which has maximum chances of Food poisoning after long time. So, as far as possible only Dry food should be supplied or the provisions are to be made for Preparing Food at Local level so as to supply Hot, Hygienic food.

Disease due to animals: This is an accidental finding many a times that after disaster, the pet animals which are survived had rabied effect. We all know that rabies in animals are possible by biting and this has definite incubation period of more than three months but rabied dogs are regular observation at such site. So, any small animal bite is to be labelled as potential for Rabies & treatment shall be made accordingly.

Other disease: For prevention of Typhoid, Tetanus & Malaria or other local disease shall be treated prophylacticly and Vaccine or Drugs related to this shall be available.

Larvicidal material like Kerosene or oil should be sprinkled over the large collection of water and should be freely available for this purpose of domestic use.

Temporary shelters for refugees should be maintained with proper hygiene. One cannot expect ideal W.H.O. conditions for space and sanitation, but as per the available resources from different sector, best provisions are to be made. The acceptable guideline during such sanitation 10 sq. ft. area for each person & one toilet facility for each 50 persons. Also, safe water supply of about 5 litres per day for drinking shall be available. Regular supply of safe Food and Milk

shall be ensured through co ordination of different voluntary agencies & preferably, Food shall be prepared at site only to prevent Food related disease.

Management of medico-legal cases

The most delicate yet responsible duty is to manage the medico-legal cases. This shall include Dead body Disposal & injury Certificate. The disaster has it's own emotional value and at times, if effects all including intelligent sections also. The social & political groups try to handle situation in their own interest, which is a biggest threat to legal machinery. The unfortunate victims of disaster have their own legal identity over & above social value which necessitates proper handling by professionals to help them in Insurance claims, Government aids etc.

Post-mortem examination: This part of Disaster management is most critical esp. due to scarcity of Forensic Personnel. Medical fraternity is afraid of such work due to the attached Legal responsibility & court attendance. The post-mortem examination of such victims is of limited use in almost all disaster both for Medical & social reasons. The only purpose of conducting such examination is to establish the identity of a person. This may not require conventional full post-mortem examination but to avoid this, administration has to resolve about the same. If we consider precedence, during Morbi disaster in Gujarat, the then Collector issued an order for Post-mortem examination only for the purpose of Identity. The same can be made as a rule so that every time, medical person can work on that guideline.

The effected area shall be divided by geographical means and each such unit shall be considered as separate entity. An in-charge medical officer shall have one Vehicle with sufficient paramedical staff & social worker. He will move into his designated area to search for any dead body & if found, then follow the guidelines issued by Medico-legal in-charge. After that, send the body to either common Funeral area made on site or hand over to relatives-

Basic guidelines for identification of dead body in disaster

- Inquire locally about the relatives or any identity
- Define the place from where the body was found.
- Take photographs in different angles & close photograph of Face.
- Confirm the sex & probable age.
- Look for any identification mark like tatoo, loss of teeth or any evident physical deformity like old scar mark.
- Measure the length of body

This photographs and clothes of unidentified person shall be displayed at one place so that others can look for their near ones.

Injury certificate: The injured person is first to be treated at Medical centre. As many of such doctors come from outside and it becomes impossible for them to attend the court when summoned. To avoid such problem, Forensic team should be given this job of issuing Injury certificate for all. This will have uniformity in description & help disabled in early claim from Insurance or Government.

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Management of other services

The management of ancillary services are as important as actual services. Those working in the field shall be free from all other incidental work so that they can better concentrate on specialised job.

Supply of drug & instruments: Almost all disasters are similar in their after-effects. The drug requirement is common to all with few additions as per the type of Disaster. This list shall be available at all district centres & to prominent people so as to make supply immediate from all sources. The sufficient quantity of drugs will boost up the morale of Doctors & also, create scene of proper care taken by Govt. agencies.

Facility to staff: The medical & paramedical staff engaged in this work should be provided with reasonable good, ventilated accommodation with enough number of beds & other basic facility like drinking water, toilets with water supply, fan & hot food at all times.

Transportation: The staff shall have enough number of vehicles for free movement in the field. These are the persons who work at ground level and are directly helping the effected people. So, for the purpose of better efficiency, they shall have pick up or pull arrangement to reach to the place of destination and also, to put them at the places of stay after the job is completed.

Communication: This is the basic need of any man who is outside his own house. This shall be freely available to all staff so that they can stay for more days and work with Human touch.

Liason with Govt. & NGOs: This is important to make govt. agencies know about the factual details of local situation and to carry out their instructions for smooth handling. This will help in controlling rumours and built confidence in local people. Liasoning with N.G.O. for proper & regular supply of food, drugs, clothes, utensils, grains, atta etc. shall be taken care so that continuous supply is maintained & nothing is wasted.

I strongly desire to publish a code of conduct for all those who are under security cover like politicians, V.I.P. & other so as to close their visit for period of 15 days so that other govt. agencies can concentrate on actual rehabilitation work and offer better services to affected people.

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